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WEDNESDAY, JANUARY 27, 1999 MORNING SESSION

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THE COURT: OKAY. MR. OHLEMEYER, YOU MAY CALL YOUR FIRST WITNESS.

MR. OHLEMEYER: VERY GOOD, YOUR HONOR. DR. GEORGE HENSLEY, H-E-N-S-L-E-Y.

TESTIMONY OF

GEORGE HENSLEY, M.D.

A WITNESS CALLED ON BEHALF OF THE DEFENDANT, HAVING BEEN DULY SWORN, TESTIFIED AS FOLLOWS:

THE CLERK: PLEASE STATE YOUR NAME.

THE WITNESS: GEORGE HENSLEY.

THE CLERK: PLEASE SPELL YOUR NAME.

THE WITNESS: H-E-N-S-L-E-Y.

THE CLERK: IS GEORGE G-E-O-R-G-E?

THE WITNESS: G-E-O-R-G-E.

THE CLERK: THANK YOU. PLEASE TAKE THE STAND.

DIRECT EXAMINATION

BY MR. OHLEMEYER: Q. GOOD MORNING, DOCTOR.

A. GOOD MORNING.

Q. YOU ARE A PATHOLOGIST; IS THAT CORRECT?

A. YES, SIR.

Q. HOW LONG HAVE YOU BEEN A PATHOLOGIST?

A. WELL, I WAS ENGAGED IN THE ACTIVE PRACTICE OF PATHOLOGY FOR SOMETHING OVER 30 YEARS. I WAS BOARD-CERTIFIED IN THE 1960S.

Q. AND WHERE DO YOU CURRENTLY PRACTICE PATHOLOGY?

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A. I'M RETIRED. I RETIRED IN 1995 FROM THE UNIVERSITY OF MIAMI SCHOOL OF MEDICINE.

Q. AND WHAT WERE YOU DOING AT THE UNIVERSITY OF MIAMI SCHOOL OF MEDICINE AT THE TIME YOU RETIRED?

A. WELL, I WAS A PROFESSOR IN THE DEPARTMENT, AND I HAD THREE GENERAL KINDS OF DUTIES. FIRST, PROVIDING DIAGNOSTIC SERVICES TO PATIENTS HOSPITALIZED AT THE TEACHING HOSPITAL. SECONDLY, TEACHING POSTGRADUATE STUDENTS IN PATHOLOGY. AND THIRDLY, CONDUCTING RESEARCH.

Q. CAN YOU TELL US WHAT DIAGNOSTIC SERVICES ARE?

A. WELL, THERE ARE TWO TYPES. THE FIRST TYPE IS SURGICAL PATHOLOGY, WHERE YOU RECEIVE BIOPSIES OR ORGANS REMOVED FROM PATIENTS WHO ARE ALIVE AND MAKE A DIAGNOSIS OF THE DISEASE.

THE SECOND CATEGORY WOULD BE THE AUTOPSY SERVICE, WHERE YOU INVESTIGATE THE DISEASES OF PATIENTS WHO HAVE DIED, MANY OF WHOM YOU SAW IN THE FIRST PHASE OF STUDY, NAMELY, THE EVALUATION OF BIOPSIES.

Q. AND WHEN YOU SAID YOU WERE INVOLVED WITH TEACHING POSTGRADUATE STUDENTS, ARE THOSE MEDICAL DOCTOR STUDENTS?

A. YES, FOR THE MOST PART, ALTHOUGH I WAS INVOLVED IN TEACHING PH.D. CANDIDATES AT THE ROSENSTIEL INSTITUTE FOR MARINE AND ATMOSPHERIC SCIENCE.

Q. AND YOU SAID YOU WERE CONDUCTING RESEARCH.

WHAT TYPE OF RESEARCH DID YOU CONDUCT?

A. WELL, OVER THE YEARS, I WORKED IN A NUMBER OF FIELDS. IN WISCONSIN, I DID A SUBSTANTIAL AMOUNT OF WORK ON LUNG DISEASE, SPECIFICALLY, HYPERSENSITIVITY, DISEASES OF

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THE LUNG. THESE ARE DISEASES CAUSED BY ALLERGIC MECHANISMS OF INJURY.

THROUGHOUT THE YEARS, I'VE WORKED IN THE AREA OF GASTROINTESTINAL TRACT PATHOLOGY. AND IN THE LAST 10 YEARS, I, LIKE MANY OTHER ACADEMIC PATHOLOGISTS, HAD TO SPEND A GOOD DEAL OF TIME WITH THE INVESTIGATION OF AIDS/HIV INFECTION.

Q. CAN YOU DESCRIBE FOR US YOUR EDUCATION, YOUR FORMAL EDUCATION THAT LED UP TO YOUR MEDICAL DEGREE.

A. WELL, I WENT TO UNDERGRADUATE SCHOOL AT NORTHWESTERN OHIO, A CITY CALLED TOLEDO. I GRADUATED WITH A BACHELOR OF SCIENCE DEGREE IN ZOOLOGY AND CHEMISTRY.

I THEN WENT TO THE OHIO STATE UNIVERSITY WHERE I GOT MY M.D. DEGREE AFTER FOUR YEARS.

Q. AND WHEN WAS THAT?

A. I THINK IT WAS ABOUT 1957, '58. YOU'LL DISCOVER MY MEMORY FOR DATES IS NOT VERY GOOD.

BUT AFTER GRADUATING FROM MEDICAL SCHOOL, I TOOK A GENERAL ROTATING INTERNSHIP WITH AN EMPHASIS ON SURGERY, MEDICINE AND SOME OBSTETRICS. THAT WAS A CLINICAL YEAR.

Q. CAN I INTERRUPT YOU FOR A MINUTE.

A. YES, SIR.

Q. CAN YOU TELL US WHAT YOU MEAN BY A "CLINICAL YEAR" IN AN INTERNSHIP.

A. WELL, DURING THAT YEAR, I WAS SEEING PATIENTS WITH A WIDE VARIETY OF DISEASES AND INJURIES. I PARTICIPATED IN THE DIAGNOSIS AND TREATMENT OF PATIENTS OF PRIVATE PRACTITIONERS OF MEDICINE.

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BUT IN ADDITION, OF COURSE, I WORKED IN THE MEDICAL CLINICS, WHERE I WAS RESPONSIBLE FOR SEEING PATIENTS AND WORKING THEM UP DIAGNOSTICALLY.

Q. AND THEN, DID YOU PROCEED TO A RESIDENCY?

A. I DID. AND FOR THAT CLINICAL YEAR, I WENT TO THE UNIVERSITY OF CINCINNATI SCHOOL OF MEDICINE. THAT'S SITUATED IN SOUTHERN OHIO. I SPENT A YEAR THERE STUDYING ANATOMIC PATHOLOGY.

AND THEN I RETURNED TO THE HOSPITAL, WHERE I TOOK MY INTERNSHIP IN TOLEDO, AND I TOOK THREE ADDITIONAL YEARS IN TRAINING IN PATHOLOGY, WHICH INVOLVED BOTH ANATOMICAL PATHOLOGY AND CLINICAL PATHOLOGY.

I REALLY EMPHASIZED ON ANATOMICAL PATHOLOGY THROUGHOUT THOSE FOUR YEARS OF TRAINING.

Q. WE HAVE HEARD A LITTLE BIT ABOUT PATHOLOGY ALREADY.

CAN YOU TELL US BRIEFLY WHAT ANATOMIC PATHOLOGY INVOLVES.

A. WELL, AN ANATOMIC PATHOLOGIST IS A PERSON WHO PRACTICES MEDICINE BY WORKING WITH OTHER PHYSICIANS TO HELP THEM MAKE DIAGNOSES AND PLAN TREATMENT.

THE THING THAT DISTINGUISHES THOSE OF US WHO WORK IN ANATOMIC PATHOLOGY IS THAT WE HOLD THINGS IN OUR HANDS AND LOOK AT THEM, AND WE USE THE MICROSCOPE A LOT, OF COURSE.

BASICALLY, WE DO WHAT I'VE ALREADY DESCRIBED, LOOK AT BIOPSIES OR ORGANS OR DO AUTOPSIES. THAT'S THE GENERAL DESCRIPTION.

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Q. DID YOU THEN OBTAIN A BOARD CERTIFICATION IN ANATOMIC PATHOLOGY?

A. I DID.

Q. AND WE'VE HEARD A LITTLE ABOUT THAT ALREADY.

TELL US BRIEFLY WHAT IS INVOLVED IN OBTAINING THE

BOARD CERTIFICATION.
A. WELL, THE BOARD CERTIFICATION, WHICH, INCIDENTALLY, WAS BASED ON AN EXAMINATION TAKEN HERE IN SAN FRANCISCO, ENTAILED TAKING A COMPREHENSIVE WRITTEN EXAMINATION, AND ALSO LOOKING AT A LARGE NUMBER OF ORGANS THAT WERE BROUGHT TO THE TESTING SITE BY EXPERTS IN THEIR FIELDS, AND EXAMINING THEM AND GIVING OPINIONS.
AND THEN, ALSO LOOKING AT MICROSCOPIC SLIDES IN THE SAME WAY.
Q. THROUGHOUT YOUR CAREER -- BY THE WAY, DOCTOR, WHEN DID YOU OBTAIN YOUR BOARD CERTIFICATION?
A. I THINK IT'S '63. IT COULD HAVE BEEN A LITTLE LATER. I'M NOT SURE.
Q. IF YOUR RESUME SAYS '63, THAT WOULD BE CONSISTENT WITH YOUR RECOLLECTION --
A. YES.
Q. -- THROUGHOUT?
A. I DON'T HAVE IT BEFORE ME.
Q. THROUGHOUT YOUR CAREER, HAVE YOU BEEN INVOLVED IN TEACHING DOCTORS AND OTHER MEDICAL STUDENTS?
A. YES. IN WISCONSIN, IN THE EARLY DAYS, I TAUGHT A LOT OF UNDERGRADUATE STUDENTS. THEY WERE STUDENTS USUALLY AT THE SENIOR LEVEL IN MEDICAL SCHOOL.

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BUT THEN, I ALSO TAUGHT PHYSICIANS WHO HAD COMPLETED MEDICAL SCHOOL AND WERE STUDYING PATHOLOGY BECAUSE THEY WISHED TO BECOME PATHOLOGISTS THEMSELVES. I CONTINUED THAT SECOND ACTIVITY IN FLORIDA THE LAST 20 YEARS.
IN ADDITION, I TAUGHT A VARIETY OF POSTGRADUATE COURSES FOR PHYSICIANS WHO WERE IN INTERNAL MEDICINE SURGERY AND PATHOLOGY.
AND AS I MENTIONED BEFORE, I WAS ON THE FACULTY OF THE ROSENSTIEL INSTITUTE, ADVISING PH.D. CANDIDATES ON THEIR THESIS.
Q. HAVE YOU DONE WHAT THEY CALL VISITING PROFESSORSHIPS?
A. YES, TWICE.
Q. TELL US WHAT THAT INVOLVES.
A. WELL, IN THE EARLY 1980S, I THINK IT WAS ABOUT 1982, I WENT TO HAITI, TO THE MEDICAL SCHOOL AT PORT AU PRINCE. THE REASON FOR MY VISIT WAS THAT THERE WAS REASON TO SUSPECT THAT HIV INFECTION WAS PRESENT ON THE ISLANDS, BUT IT HAD NEVER BEEN PROVEN.
THE FACULTY THERE LACKED SOME OF THE SKILLS AND RESOURCES THAT WE HAD IN MIAMI, SO I WENT DOWN TO HELP THEM TO DEVELOP THEIR RESOURCES AND SKILLS AND LOOK FOR THE INFECTION.
AND SURE ENOUGH, WE DID FIND A SIGNIFICANT NUMBER OF PATIENTS AT THE UNIVERSITY HOSPITAL WHO DID HAVE HIV INFECTION AND WHO HAD AIDS.
AROUND THE SAME TIME, I WENT TO MEXICO CITY FOR WHAT TURNED OUT TO BE AN ABBREVIATED TRIP, ONLY ABOUT SIX

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WEEKS, WHERE I WAS A VISITING PROFESSOR. THE FACULTY OF THE AUTONOMOUS UNIVERSITY.
I WAS INVITED THERE BY THE CHAIRMAN, DR. ALBERTO SAAVEDRA, S-A-V-A-A-D-R-A, TO PARTICIPATE IN TEACHING HIS STUDENTS, AND ALSO TO LOOK AT THE QUESTION OF AIDS IN MEXICO.
WHILE THERE, WE DID FIND THE FIRST CASE IN MEXICO.

Q. THROUGHOUT THE YEARS, HAVE YOU HAD ADMINISTRATIVE RESPONSIBILITIES AT THE UNIVERSITY?
A. FROM TIME TO TIME, YES, I HAVE SERVED AS DIRECTOR OF THE AUTOPSY SERVICE.
I'VE ALSO SERVED AS DIRECTOR OF ANATOMICAL PATHOLOGY, WHICH INCLUDES THE SURGICAL PATHOLOGY AREA, AUTOPSY AND CYTOLOGY.
I'VE HELD OTHER ADMINISTRATIVE POSITIONS IN THE DEPARTMENT FROM TIME TO TIME, BUT I TRIED TO AVOID AS MUCH AS POSSIBLE ADMINISTRATIVE RESPONSIBILITIES.
Q. IT LEAVES MORE TIME --
A. FOR WORK.
Q. YOU MENTIONED THAT YOU CONDUCTED RESEARCH OVER THE YEARS.
HAVE YOU PUBLISHED THE RESULTS OF THAT RESEARCH IN MEDICAL AND SCIENTIFIC JOURNALS?
A. YES.
Q. WHAT SORTS OF JOURNALS HAVE YOU PUBLISHED YOUR RESEARCH IN?
A. WELL, REALLY, THEY ARE QUITE DIVERSE. I HAVE

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PUBLISHED, OF COURSE, IN THE PATHOLOGY JOURNALS, THE STANDARD ONES.
BUT IN ADDITION, THERE ARE TITLES IN THE JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION, GASTROENTEROLOGY AND OTHER CLINICAL JOURNALS, BECAUSE A LOT OF MY WORK HAS TO DO WITH WORKING JOINTLY AND COOPERATIVELY WITH PHYSICIANS IN OTHER SPECIALTIES.
Q. DOCTOR, IN TERMS OF YOUR BACKGROUND, YOUR EDUCATION, HOW DO YOU APPLY THAT TO THE STUDY OF DISEASE BY PATHOLOGICAL METHODS?
A. WELL, I THINK AN ANATOMIC PATHOLOGIST IS A PERSON WHO SHOULD HAVE AN OPEN MIND WHEN A DIAGNOSTIC PROBLEM IS BROUGHT TO HIM, AND HE SHOULD HAVE AN INDEPENDENT VIEWPOINT BASED ON ANATOMY AND THE PRINCIPLES OF DISEASE PROCESSES AS THEY RELATE TO ALTERED OR ABNORMAL ANATOMY.
SO WHAT WE DO IS INDEPENDENTLY LOOK AT THE PROBLEM AND USE OUR TOOLS -- THE MICROSCOPE, OUR HANDS AND OUR EYES -- IN ARRIVING AT A PATHOLOGICAL DIAGNOSIS, THE DIAGNOSIS WE HOPE IS HELPFUL TO THE CLINICIAN. AND IN MOST CASES, IT IS.
Q. AND WHEN YOU SAY "HELPFUL TO THE CLINICIAN," YOU MEAN IN TREATING AND MANAGING THE CARE OF THE PATIENT?
A. AND IN ESTABLISHING THE ACTUAL DIAGNOSIS AS WELL, YES.
Q. HAVE YOU BEEN INVOLVED IN DIAGNOSING CANCER?
A. OH, YES.
Q. HAVE YOU BEEN INVOLVED IN THE DIAGNOSIS OF CANCERS THAT START IN THE LUNG?

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A. YES.
Q. HAVE YOU BEEN INVOLVED IN -- DO YOU HAVE ANY EXPERIENCE WITH RESPECT TO AUTOPSIES?
A. YES. ACTUALLY, I HAVE HAD A CONTINUING INVOLVEMENT IN AUTOPSIES OF HUMAN BEINGS.
Q. DOCTOR, YOU MENTIONED -- I THINK WE'VE ALSO HEARD "PATHOLOGICAL DIAGNOSIS."
WITH RESPECT TO CANCER, CAN YOU DESCRIBE FOR US HOW A PATHOLOGIST IS ABLE TO DIAGNOSE CANCER IN A PATIENT.
A. WELL, WE'RE TALKING ABOUT A LIVING PATIENT, I PRESUME?

Q. CORRECT.
A. AND LET'S SAY A PATIENT IS SUSPECTED TO HAVE CANCER. WE, OF COURSE, RECOMMEND TO THE SURGEON THAT TO MAKE THE DIAGNOSIS, THEY GO LOOKING WHERE THE TUMOR IS SUSPECTED TO BE, AND THEN TO PROCURE A TISSUE SAMPLE THAT WE CAN PREPARE FOR EXAMINATION UNDER THE MICROSCOPE.
Q. ARE THERE OTHER TOOLS YOU CAN USE BESIDES AN ACTUAL TISSUE SAMPLE TO HELP DIAGNOSE CANCER?
A. WELL, IN THOSE CASES WHERE BIOPSY IS DIFFICULT OR IMPOSSIBLE, YOU MAY HAVE TO RELY ON EXFOLIATED CYTOLOGY; THAT IS TO SAY, THE EXAMINATION OF CELLS SHED FROM THE SURFACE OF THE SUSPECTED TUMOR.
THE PROBLEM WITH THAT IS THAT IT CANNOT TELL YOU WITH CONFIDENCE THE SITE OF ORIGIN OF THE TUMOR IN MOST CASES, AND OCCASIONALLY, IT DOESN'T EVEN TELL YOU CELL TYPE. SO THERE ARE SOME LIMITATIONS ON CYTOLOGY.
Q. IS SPUTUM ANALYSIS, SPUTUM CYTOLOGY AN EXAMPLE OF

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THAT?
A. YES. IT HAS VERY LIMITED APPLICATION TO THE DIAGNOSIS OF CANCER OF THE LUNG, HOWEVER.
Q. AND WHY IS THAT?
A. WELL, ONLY ABOUT HALF OR A LITTLE LESS THAN HALF OF CANCERS ORIGINATING WITHIN THE LUNG ARE SITUATED CENTRALLY, WHERE THEY SHED CELLS THAT WE CAN PICK UP BY CYTOLOGIC EXAMINATION.
THE OTHERS, WHICH MAY BE A SLIGHT MAJORITY, IF NOT ABOUT HALF, ARE SO FAR OUT IN THE LUNG PARENCHYMA THAT ANY SHED CELLS DON'T SEEM TO GET INTO THE BRONCHIAL TREE AND COME OUT WHERE WE CAN FIND THEM.
Q. IN CASES IN WHICH A SMALL CELL CARCINOMA IS FOUND TO BE GROWING OR TO HAVE STARTED IN THE LUNG, WHAT ROLE OR WHAT USE CAN YOU MAKE OF SPUTUM CYTOLOGY IN THE DIAGNOSIS OF THAT DISEASE?
A. WELL, I WOULD SAY THAT SPUTUM CYTOLOGY IS NOT A RELIABLE TOOL. I WOULDN'T DEPEND UPON IT.
Q. YOU'D WANT MORE INFORMATION TO DIAGNOSE THE DISEASE?
A. WELL, IF I WANTED TO RELY ON CYTOLOGY IN SUCH A PATIENT, WHICH I WOULD RECOMMEND DOING -- WHAT I WOULD RECOMMEND DOING IS TO DO A BRONCHOSCOPY, AND THEN TO GET THE CELLS DIRECTLY FROM THE SURFACE OF THE BRONCHUS IN QUESTION. AND PERHAPS TO DO WHAT WE CALL BRONCHIAL WASHINGS AND BRUSHINGS, TO MAKE SURE THAT WE OPTIMIZE THE PROBABILITY OF FINDING DIAGNOSTIC CELLS.
THE ADVANTAGE OF THAT IS, I CAN TELL YOU WHERE

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THE TUMOR IS, WHEREAS IF YOU GET MALIGNANT CELLS IN THE SPUTUM CYTOLOGY, THERE IS NO CORRELATION WITH THE SITE INVOLVED.
Q. HOW OFTEN IS SPUTUM CYTOLOGY POSITIVE IN CASES IN WHICH A SMALL CELL CARCINOMA IS ULTIMATELY FOUND TO BEGIN OR HAVE BEGUN GROWING IN THE LUNG?
A. WELL, IF I UNDERSTAND YOUR QUESTION -- MAY I PARAPHRASE IT?
Q. CERTAINLY.
A. IF THE QUESTION IS: HOW OFTEN CAN YOU FIND MALIGNANT CELLS BY CYTOLOGIC EXAMINATION IN A PERSON SUSPECTED TO HAVE BRONCHOGENIC CARCINOMA, I WOULD SAY THE ANSWER IS THAT IF YOU USE THE TECHNIQUE OF BRONCHOSCOPY WITH BRONCHIAL BRUSHINGS AND WASHINGS, WHICH I MENTIONED BEFORE,

THERE'S A HIGH PROBABILITY THAT YOU WILL FIND THE MALIGNANT CELLS, VERY HIGH.

I WOULDN'T WANT TO QUOTE A NUMBER OFF THE TOP OF MY HEAD, BUT YOU WOULD NEED TO USE THAT METHOD. AND IT'S A FAIRLY COMMON METHOD, A STANDARD APPROACH.

Q. CAN CANCER BE A DIFFICULT DISEASE TO DIAGNOSE?

A. IT CAN BE EXCEPTIONALLY CHALLENGING, YES.

Q. AND CAN DETERMINING WHERE IN THE BODY A PARTICULAR CANCER BEGAN GROWING BE A DIFFICULT PROCESS?

A. INDEED, IT CAN. IF YOU LOOK AT THE QUESTION FROM THE STANDPOINT OF TUMORS THAT ARE DISCOVERED IN THE LUNG, FOR EXAMPLE, STUDIES HAVE SHOWN THAT SOMEWHERE AROUND 15 TO 20 PERCENT OF THE TUMORS FIRST PRESENTING IN THE LUNG HAVE STARTED OUT ELSEWHERE IN THE BODY, AND IT MIGHT BE VERY

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DIFFICULT TO ESTABLISH THAT WITHOUT A THOROUGH CLINICAL WORKUP.

AND SOMETIMES, I REGRET TO SAY, EVEN AUTOPSY MAY BE NECESSARY TO DISCOVER THE SITE.

Q. HOW OFTEN DOES AN AUTOPSY -- IN YOUR EXPERIENCE, HOW OFTEN DOES AN AUTOPSY PROVIDE INFORMATION TO THE DOCTORS ABOUT THE PLACE WHERE THE CANCER MIGHT HAVE STARTED GROWING THAT IS UNAVAILABLE OR UNKNOWN TO THEM DURING LIFE?

A. USUALLY, WE CAN ANSWER THE QUESTION. IT'S ONLY A VERY TINY FRACTION OF CASES THAT AT AUTOPSY WE FAIL TO ESTABLISH WHERE THE PRIMARY SITE IS THAT IS NEWS TO THE PERSON TREATING THE PATIENT.

IN A SUBSTANTIAL NUMBER OF CASES -- IN FACT, MOST STUDIES HAVE SHOWN THAT AROUND 40 PERCENT OF THE TIME, A LITTLE LESS, A LITTLE MORE, DEPENDING ON THE STUDY, THE DOCTOR TAKING CARE OF THE PATIENT DURING LIFE EITHER DIDN'T KNOW THE PATIENT HAD CANCER AT ALL OR HE KNEW THE PATIENT HAD CANCER BUT HE DIDN'T KNOW WHAT CANCER IT WAS.

Q. WHAT IS IT ABOUT CANCER THAT MAKES IT EITHER DIFFICULT TO DIAGNOSE IN THE FIRST INSTANCE OR DIFFICULT TO DETERMINE THE POINT IN THE BODY WHERE IT ORIGINATED?

A. WELL, FOR ONE THING, IT SPREADS. AND OFTEN, YOU KNOW, THE SYMPTOMS OF CANCER ARE NOT APPARENT AT THE SITE WHERE THEY ORIGINATE.

FOR EXAMPLE, IN THE PANCREAS, IT'S VERY TYPICAL TO HAVE THE PATIENT SUFFER SIGNS AND SYMPTOMS REFERRING TO OTHER AREAS OF THE BODY THAN THE PANCREAS. AND FREQUENTLY, IT'S NOT UNTIL AUTOPSY THAT YOU CAN FIND TUMORS ORIGINATING

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THERE.

SECONDLY -- OR TO ANSWER THE SECOND PART OF YOUR QUESTION, IT'S SOMETIMES DIFFICULT EVEN WITH A BIOPSY TO SAY FOR SURE THAT YOU GOT THE SITE OF THE TUMOR.

WHAT WE PATHOLOGISTS USUALLY NEED IS SOME OF THE TISSUE, THAT IS THAT'S NORMAL, IN ADDITION TO THE CANCER TISSUE, SO THAT WE CAN SEE NOT ONLY THE TUMOR, BUT THE TRANSITION FROM THE CANCER TO THE NORMAL TISSUE FROM WHICH IT ORIGINATED.

AND SOMETIMES, THE BIOPSY DOESN'T INCLUDE THAT, ESPECIALLY IN THE CASE OF VERY SMALL BIOPSIES LIKE FINE NEEDLE ASPIRATIONS THAT ARE COMMONLY USED, AND BRONCHIAL BIOPSIES. THERE'S VERY SMALL TISSUES TO MEASURE, IN MILLIMETERS.

Q. DO CANCERS LOOK THE SAME? HOW DOES A CANCER -- CAN YOU DISTINGUISH WHERE IN THE BODY A CANCER STARTED BY HOW IT LOOKS UNDER THE MICROSCOPE?

A. SOMETIMES, BUT NOT VERY OFTEN.
THE FACT IS, MANY DIFFERENT ORGANS OF THE BODY WILL YIELD CANCERS THAT HAVE THE SAME CELL TYPE. WHEN THAT OCCURS, AND IF YOU DON'T HAVE THAT TRANSITION BETWEEN THE CANCER AND THE NORMAL TISSUE WHICH I MENTIONED, YOU JUST SIMPLY CANNOT BE SURE WHERE THE CANCER ORIGINATED FROM.
IT'S A RATHER IMPORTANT POINT THAT I TRIED TO TEACH POSTGRADUATE STUDENTS AND OTHER STUDENTS OF PATHOLOGY, THAT IF YOU CAN'T SEE THE ORIGIN OF A TUMOR, YOU SHOULDN'T USE A SIMPLE DECLARATIVE SENTENCE AND SAY THAT IT ORIGINATED AT A PARTICULAR SITE. YOU SHOULD PHRASE THE DIAGNOSIS SO

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THE CLINICIAN KNOWS THAT YOU DON'T KNOW FOR SURE WHERE THE TUMOR ORIGINATED FROM.
Q. HOW OFTEN -- STRIKE THAT.
WHEN YOU OR A DOCTOR HAS A BIOPSY THAT WAS OBTAINED FROM A SPECIFIC LOCATION IN THE BODY, AS I UNDERSTAND WHAT YOU SAID, SOMETIMES THERE ARE THINGS ATTACHED TO THE TUMOR THAT ALLOW YOU TO DETERMINE WHERE IT MIGHT HAVE STARTED?
A. YES, SIR.
Q. WHEN YOU DON'T HAVE INFORMATION LIKE THAT BUT YOU KNOW FROM WHERE IN THE BODY THE BIOPSY WAS OBTAINED, DOES THAT -- HOW OFTEN DOES THAT GIVE YOU ENOUGH INFORMATION TO DETERMINE WHETHER THAT'S THE PLACE WHERE THE CANCER STARTED?
A. WELL, PRACTICALLY NEVER. THE FACT IS THAT WE PATHOLOGISTS, AS I SAID BEFORE, HAVE TO HAVE AN INDEPENDENT OPINION TO MAKE A VALUABLE DIAGNOSTIC JUDGMENT.
WE CANNOT TAKE THE CLINICAL INFORMATION PROVIDED TO US AND RUBBER-STAMP IT IN TERMS OF THAT BEING THE PROBABLE SITE OF ORIGIN. WE MUST CRITICALLY EXAMINE THE QUESTION.
Q. WHAT INFORMATION OR WHAT TOOLS DO YOU USE TO CONDUCT THAT EXAMINATION?
A. WELL, AS I SAID, IN THE FINAL ANALYSIS, IF YOU DON'T HAVE A TRANSITION OF THE NORMAL TISSUE WITH THE CANCER, YOU CAN NEVER BE 100 PERCENT CERTAIN OF THE SITE OF ORIGIN.
BUT ON THE OTHER HAND, OF COURSE, WHEN WE'RE NOT SURE, USUALLY THE SURGEON TURNS UP IN OUR OFFICE OR AT LEAST

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ON THE TELEPHONE AND WE DISCUSS THE CASES WITH THEM FROM THEIR STANDPOINT.
AND SOMETIMES, WE CAN REVIEW THE CT'S OR THE X-RAYS AND WE CAN TAKE THAT INFORMATION, AND IN DISCUSSING THE CASE WITH THE CLINICIANS, WE CAN SAY, "WELL, YOU KNOW, YOUR DIAGNOSIS SEEMS TO BE WELL-FOUNDED OR NOT," AND YET WE CANNOT NECESSARILY SAY IT'S DEFINITELY CORRECT, BECAUSE IN THE FINAL ANALYSIS, THOSE OTHER LINES OF EVIDENCE ARE NOT WITHIN OUR DIRECT CONTROL TO ASSURE THEIR QUALITY AND MEANING.
Q. WHAT ABOUT A PATIENT'S HISTORY OR SYMPTOMS OR A PHYSICAL EXAMINATION CONDUCTED BY A DOCTOR, WHAT CAN THAT TELL YOU AS A PATHOLOGIST ABOUT WHERE IN THE BODY A CANCER MIGHT HAVE STARTED?
A. WELL, IN EASY CASES, A LOT. I MEAN, YOU KNOW, IF THE DERMATOLOGIST TELLS US HE'S GOT A PIGMENTED LESION OF THE SKIN AND WE HAVE A SLIDE OF THE SKIN THAT SHOWS MALIGNANT MELANOMA, I MEAN, THAT'S VERY HELPFUL.
IT'S JUST THAT, UNHAPPILY, MOST OF THE CANCERS THAT WE'RE DEALING WITH ARE DEEPER IN THE BODY.

Q. AND HOW OFTEN, WITH RESPECT TO TUMORS THAT ARE SUSPECTED OF BEING EITHER IN OR OF THE LUNG, DO YOU HAVE BIOPSY MATERIAL OBTAINED FROM EITHER A BRONCHOSCOPY OR ANOTHER TYPE OF INVASIVE PROCEDURE?

A. WELL, USUALLY. I WOULDN'T SAY ALWAYS. THE UNIVERSITIES WITH WHICH I'VE BEEN AFFILIATED, IT'S BEEN THE POLICY TO USE BRONCHIAL BRUSHINGS AND WASHINGS, CYTOLOGIES FOR THE DIAGNOSIS OF BRONCHOGENIC CARCINOMA, AND ALSO TO DO

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BIOPSIES EVEN IF NO CANCER IS OBSERVED IN THE BRONCHUS.

THOSE TECHNIQUES ARE HIGHLY RELIABLE.

Q. I WANT TO ASK YOU NOW, DOCTOR, TO TALK SPECIFICALLY ABOUT MS. HENLEY'S SITUATION.

BUT JUST BRIEFLY, BEFORE I DO, LET ME ASK YOU ABOUT DIFFERENT CELL TYPES OF CANCER.

WE HAVE HEARD A LITTLE BIT ALREADY ABOUT SOMETHING CALLED SMALL CELL CARCINOMA.

IN GENERAL TERMS, WHY OR HOW ARE CANCERS DISTINGUISHED BY CELL TYPE?

A. THE MAIN THRUST OF DISTINGUISHING CELL TYPES OF CANCERS CAME FROM THE WORLD HEALTH ORGANIZATION AND A NORWEGIAN PATHOLOGIST BY THE NAME OF KREYRG, K-R-E-Y-R-G. THEY WANTED TO SEE IF THE CELL TYPES THAT HAD BEEN PREVIOUSLY DESCRIBED BY OTHERS REFLECTED DIFFERENCES IN THEIR BIOLOGY AND POSSIBLY THEIR CAUSATION.

SO THEY DEVELOPED A SCHEME OF DESCRIBING CERTAIN CELL TYPES AND PROPOSED THAT PATHOLOGISTS THROUGHOUT THE WORLD SHOULD USE IT SO THAT, IN THE FUTURE, WE COULD FIND OUT IF THE VARIOUS CELL TYPES REFLECTED DIFFERENT BIOLOGIC PATTERNS OF BEHAVIOR.

Q. AND BY THAT, YOU MEAN WHETHER THEY BEHAVED DIFFERENTLY AFTER THEY HAVE BEEN FOUND?

A. YES, SIR. YOU KNOW, FOR EXAMPLE, EVERYBODY KNEW THAT SMALL CELL ANAPLASTIC CARCINOMAS OF BRONCHIAL ORIGIN HAD A TERRIBLE PROGNOSIS.

BUT THE QUESTION WAS: WHAT ABOUT THE OTHER CELL TYPES, THE ADENOCARCINOMAS, THE SQUAMOUS CELLS. THE

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DIFFERENCES WERE NOT ABSOLUTELY APPARENT WHEN KREYRG AND OTHERS WANTED TO DISTINGUISH THESE VARIOUS CELL TYPES.

SO THEY SET UP THE CLASSIFICATION SCHEME, AND IT'S BEEN VERY USEFUL.

Q. WHEN A DOCTOR IS TRYING TO DIAGNOSE CANCER IN A PATIENT, IS IT IMPORTANT TO DETERMINE WHAT THE CELL TYPE OF THAT CANCER IS?

A. WELL, FROM MY STANDPOINT, YES. IT'S EXTREMELY IMPORTANT TO KNOW THE CELL TYPE. BUT IT'S ALSO EXTREMELY IMPORTANT TO KNOW FROM WHERE THE TUMOR ORIGINATED. BECAUSE AS WE HAVE ALREADY HINTED AT THIS MORNING, THE VARIOUS ORGANS OF THE BODY CAN GIVE RISE TO THE SAME CELL TYPES OF CANCER. AND YOU CERTAINLY WANT TO TREAT THE PRIMARY SITE SPECIFICALLY, IF YOU CAN.

Q. WITH RESPECT TO WHAT WE HAVE REFERRED TO AS SMALL CELL CANCER OR SMALL CELL CARCINOMA, I THINK YOU EVEN SAID SMALL CELL ANAPLASTIC CARCINOMA THAT IS GENERALLY THE SAME.

I REALIZE THERE ARE PROBABLY MORE PRECISE WAYS TO DESCRIBE IT, BUT IS THAT GENERALLY REFERRED TO AS THE SAME TYPE OF TUMOR?

A. YES, IN A GENERAL WAY. AND THEY CAN ALL BE REGARDED AS SYNONYMOUS, I THINK, FOR THE PURPOSES OF THIS DISCUSSION.

I BELIEVE THAT IT'S PREFERABLE TO USE THE TERM "SMALL CELL ANAPLASTIC CARCINOMA" WHEN WE'RE TALKING ABOUT TUMORS OF BRONCHOGENIC ORIGIN, BECAUSE THERE ARE LOTS OF OTHER SMALL CELL TUMORS THAT ARE UNRELATED TO BRONCHOGENIC CARCINOMA WHICH MAY BE CONFUSED WITH IT.

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Q. WHEN YOU SAY "BRONCHOGENIC ORIGIN," YOU MEAN A TUMOR THAT ACTUALLY STARTS GROWING IN THE LUNG?

A. NOT ONLY IN THE LUNG, BUT IN THE LARGER BRANCHES OF THE WINDPIPE OR THE TRACHEA.

WE'RE TALKING, FOR THE MOST PART -- NOT EXCLUSIVELY, BUT FOR THE MOST PART, WE'RE TALKING ABOUT TUMORS THAT ORIGINATED CLOSE TO THE CENTER OF YOUR CHEST. WE CALL THEM CENTRALLY LOCATED (INDICATING).

THEY DON'T ORIGINALLY ORIGINATE FROM THE BREATHING TUBES FARTHER OUT IN THE LUNG.

Q. AND WOULD THAT BE WITHIN THE CENTER -- WHEN YOU SAY "CENTER OF THE CHEST," DO YOU MEAN IN THE LUNG OR OUT OF THE LUNG?

A. WELL, SOME OF THEM ORIGINATE IN THE BRONCHI, OUTSIDE OF THE LUNG, BUT MOST, JUST ABOUT WHERE THE BRONCHI ENTER INTO THE LUNG, THE REGION THAT WE CALL THE HILUM.

Q. WOULD A TUMOR THAT WAS IN THE BRONCHI BE DESCRIBED OR BE OBSERVABLE AS AN ENDOBRONCHIAL LESION?

A. AS A RULE, YES, BUT NOT INVARIABLY.

Q. AND "ENDOBRONCHIAL" MEANING INSIDE THE AIRWAY?

A. YES, SIR.

Q. NOW, HOW IS IT POSSIBLE WHEN YOU LOOK AT A TUMOR UNDER THE MICROSCOPE TO DETERMINE WHAT CAUSED IT BY LOOKING AT IT?

A. NO. WHAT WE SEE ARE THE CELLS THAT COMPOSE THE CANCER, AND WE HAVE NO IDEA ABOUT CAUSATION FROM LOOKING AT THE CELLS THEMSELVES.

Q. WOULD THE CELLS LOOK THE SAME? IF YOU HAD TWO

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TUMORS OF THE SAME CELL TYPE BUT THAT HAD BEEN CAUSED BY DIFFERENT THINGS, WOULD THEY LOOK THE SAME UNDER THE MICROSCOPE?

A. YES, SIR.

Q. NOW, LET ME ASK YOU SPECIFICALLY, DOCTOR, ABOUT MS. HENLEY.

AT MY REQUEST AND THE REQUEST OF ONE OF MY LAW PARTNERS, DID YOU LOOK AT THE CYTOLOGY MATERIALS AND THE BIOPSY MATERIAL TAKEN FROM MS. HENLEY?

A. YES, SIR, I DID.

Q. DID YOU ALSO HAVE AN OPPORTUNITY TO REVIEW MEDICAL RECORDS?

A. SUBSEQUENT TO THE ORIGINAL -- SUBSEQUENT TO THE ORIGINAL EXAMINATION OF THE SLIDES THAT YOU DESCRIBED, I DID REVIEW THE MEDICAL RECORDS.

Q. AND THEN THE X-RAYS AND THE CT SCAN?

A. YES. THAT WAS AT A STILL LATER DATE.

Q. IS THERE A REASON THAT YOU LOOKED AT THINGS IN THAT ORDER?

A. YES.

Q. CAN YOU EXPLAIN THAT FOR ME?

I MEAN, LET ME ASK YOU THIS: IS IT YOUR STANDARD PRACTICE TO LOOK AT THAT KIND OF INFORMATION IN THAT ORDER?

A. IT IS.

Q. WHY IS THAT?

A. I THINK IT'S VITALLY IMPORTANT THAT WE

PATHOLOGISTS DEVELOP INDEPENDENT DIAGNOSTIC OPINIONS, INDEPENDENT OF INFORMATION SUPPLIED TO US. IT PROVIDES US

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WITH THE OBJECTIVITY THAT WE REALLY NEED IN OUR WORK.

FOR THAT REASON, IT'S ALWAYS BEEN MY PRACTICE, AND I'VE ALWAYS TAUGHT OTHERS, THAT THEY SHOULD FIRST LOOK AT THE ANATOMICAL MATERIAL, WITHOUT A CLINICAL HISTORY, AND THEY SHOULD DEVELOP A PRELIMINARY PATHOLOGIC DIAGNOSIS.

AND THEN, VERY IMPORTANTLY, THEY SHOULD GET ALL THE CLINICAL INFORMATION THAT'S AVAILABLE TO THEM SO THAT THEY CAN CRITIQUE THEIR PATHOLOGIC DIAGNOSIS AND MAKE SURE IT MAKES SENSE FROM A CLINICAL STANDPOINT.

THAT SEQUENCE ASSURES US OF REASONABLE INDEPENDENCE OF JUDGMENT, BUT IT DOESN'T DEPRIVE US IN THE FINAL ANALYSIS OF LOOKING AT THE PATIENT AS A PERSON RATHER THAN SIMPLY SOMETHING UNDER THE MICROSCOPE.

Q. AND IN THIS INSTANCE, DR. HENSLEY, IS THERE ANY DOUBT THAT MS. HENLEY HAD A SMALL CELL CARCINOMA?

A. NONE WHATEVER.

Q. IS THERE ANY WAY TO DETERMINE WITH REASONABLE CERTAINTY WHERE IN HER BODY IT BEGAN?

A. AT THIS POINT, I THINK YOU CAN SAY THAT IT WOULD BE IMPOSSIBLE. THE PROBLEM THAT WE'RE CONFRONTED WITH ON THIS PARTICULAR CASE --

MS. CHABER: YOUR HONOR, I WOULD JUST OBJECT TO THE NARRATIVE. I THINK HE ANSWERED THE QUESTION.

I MOVE TO STRIKE.

THE COURT: I DON'T --

MR. OHLEMEYER: Q. DOCTOR --

THE COURT: I DON'T THINK HE GOT STARTED VERY FAR ON ANYTHING BEYOND THE ANSWER TO THE QUESTION. I'M

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GOING TO LEAVE IT IN.

BUT YOU CAN GO AHEAD. ASK THE NEXT QUESTION.

MR. OHLEMEYER: Q. DOCTOR, CAN YOU DESCRIBE FOR ME THE BASIS OF YOUR OPINION THAT IT'S NOT POSSIBLE TO DETERMINE WITH REASONABLE CERTAINTY WHERE THIS CANCER BEGAN.

A. YES. I MENTIONED BEFORE, THE FIRST PRINCIPLE, IF YOU'RE GOING TO MAKE A DIAGNOSIS IN A CASE LIKE THIS, IS TO LOOK WHERE YOU THINK THE TUMOR ORIGINATED AND TO BIOPSY IT AND TO GET THE CYTOLOGY FROM THAT LOCATION.

YOU CAN THEN EITHER HAVE A SHOT AT LOOKING AT THAT TRANSITION ZONE THAT I DESCRIBED AND PROVE THAT THAT'S THE SITE OF ORIGIN, OR CONTRARYWISE.

Q. AND WOULD THAT BE THE TRANSITION BETWEEN NORMAL TISSUE AND CANCEROUS TISSUE?

A. YES, SIR.

Q. IN THIS CASE, WHERE OR FROM WHAT PART OF THE BODY WAS THE TISSUE OBTAINED FROM WHICH THE BIOPSY WAS PREPARED?

A. THE PATIENT'S MEDIASTINUM.

Q. WAS THERE TISSUE BIOPSIED IN THIS CASE FROM THE LUNG?

A. NO.

Q. WAS THERE ANY LYMPH NODE TISSUE IN THE BIOPSY THAT WAS PREPARED IN THIS CASE?

A. NO.

Q. IN YOUR OPINION, DOCTOR, IS THERE ANY SIGNIFICANCE TO THE FACT THAT THERE WAS NO LYMPH NODE TISSUE BIOPSIED WITH RESPECT TO THE QUESTION OF WHERE THIS CANCER

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MIGHT HAVE STARTED?
A. YES.
Q. CAN YOU EXPLAIN THAT FOR US.
A. WELL, FROM THE PATHOLOGIC STANDPOINT, GIVEN THE LOCATION OF THE PROBLEM, WE'RE DEALING WITH A DIFFERENTIAL DIAGNOSIS OF BRONCHOGENIC CARCINOMA VERSUS CANCER THAT SPREAD TO THE CHEST. AND THE FACT THAT BRONCHOGENIC CARCINOMA IS FIRST CARCINOMA IS TOO IMPORTANT TO DEAL WITH HERE.
HOW DOES IT SPREAD OUTSIDE OF THE BRONCHUS?
WELL, IT SPREADS TO THE LYMPH NODES, TYPICALLY, AS ANAPLASTIC CARCINOMAS OF LYMPH NODES, PRESENT AS MULTIPLE ENLARGED LYMPH NODES AROUND THE BRONCHUS WHERE THE CANCER IS.
IN FACT, THE LYMPH NODES ARE USUALLY THE PREDOMINANT ANATOMIC STRUCTURE THAT'S SEEN, THE ABNORMAL LYMPH NODES THAT CONTAIN THE CANCER.
Q. LET ME INTERRUPT YOU THERE AND ASK YOU TO EXPLAIN A COUPLE OF THINGS YOU SAID.
WHEN YOU SAY SMALL CELL CARCINOMA OF THE LUNG TYPICALLY SPREADS TO THE LYMPH NODES, WHAT DO YOU MEAN BY "TYPICALLY"?
A. ALMOST ALWAYS IN SMALL CELL ANAPLASTIC CARCINOMA OF THE LUNG, THE REGIONAL LYMPH NODES IN THE CHEST SHOW A MULTITUDE OF METASTATIC LESIONS THAT EVEN ARE ENLARGED MORE THAN THAT.
IT'S NOT UNCOMMON FOR THESE METASTATIC LESIONS TO OCCUR IN LYMPH NODES WITHIN THE ABDOMEN AND NECK AS WELL.

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Q. IS THERE ANY EVIDENCE IN THIS CASE OF THE SPREAD TO REGIONAL LYMPH NODES OR LYMPH NODES IN THE ABDOMEN OR NECK?
A. NO.
Q. AND WHAT, IF ANYTHING, DOES THAT TELL YOU ABOUT WHERE THE TUMOR MIGHT HAVE STARTED OR IS LIKELY TO HAVE STARTED?
A. WELL, THE FAILURE TO OBSERVE MULTIPLE NODAL METASTASES IN THIS CASE IS SO UNUSUAL THAT IT RAISES THE QUESTION OF WHETHER THE DIAGNOSIS OF BRONCHOGENIC CARCINOMA IS CORRECT. MORE THAN THAT, I COULDN'T SAY.
Q. WHEN YOU SAY IT'S SO UNUSUAL, IN RELATION TO WHAT IS IT SO UNUSUAL?
A. WELL, THE TYPICAL BEHAVIOR OF SMALL CELL ANAPLASTIC CARCINOMA, AS I SAID, THE GREAT MAJORITY OF CASES HAVE MULTIPLE LYMPH NODES THAT ARE POSITIVE FOR CANCER, THAT ARE READILY VISUALIZED BY X-RAY OR BY CT STUDIES OF THE CHEST.
IN FACT, PRIOR TO THE RECOGNITION OF THAT CELL TYPE OF CANCER IN THE 1920S, MANY PEOPLE DIAGNOSED THESE CANCERS OF THE LUNG AS LYMPHOMA BECAUSE THE PREDOMINANT LESION WAS IN THE LYMPH NODES.
SO THIS LADY DIDN'T SHOW THAT. THE X-RAY PICTURES AND THE OTHER FEATURES HERE WERE TOTALLY DIFFERENT.
Q. BASED ON YOUR EXPERIENCE, DOCTOR, AND YOUR BACKGROUND, IF MS. HENLEY HAD A CANCER THAT HAD STARTED GROWING IN HER LUNG, WOULD YOU HAVE EXPECTED TO FIND EVIDENCE OF IT IN THE LYMPH NODES?

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A. ABSOLUTELY.
Q. ARE THERE OTHER PARTS OF THE BODY, INCLUDING

THINGS WITHIN THE MEDIASTINUM, IN WHICH SMALL CELL CARCINOMA CAN BEGIN GROWING?

A. YES.

Q. AND WHEN SMALL CELL CARCINOMA BEGINS GROWING AT ANY POINT IN THE BODY, IS IT POSSIBLE OR TYPICAL FOR IT TO SPREAD TO OTHER PARTS OF THE BODY?

A. YES, SIR.

Q. IS THERE ANY WAY TO DETERMINE WITH REASONABLE CERTAINTY, DOCTOR -- LET ME REPHRASE THE QUESTION.

I WANT TO FOCUS NOW ON THE LUNG AS OPPOSED TO WHERE ELSE IN THE BODY THE CANCER MIGHT HAVE STARTED.

CAN YOU DETERMINE OR COME TO AN OPINION WITH REASONABLE CERTAINTY AS TO WHETHER THIS CANCER STARTED IN THE LUNG?

A. THERE'S NO EVIDENCE THAT IT STARTED IN THE LUNG.

Q. AND CAN YOU EXPLAIN THE BASIS OF THAT OPINION FOR ME.

A. WELL, AS I SAID, THE FIRST THING ONE DOES IS TO LOOK WHERE YOU THINK THE TUMOR IS, AND THAT WAS DONE IN THIS CASE, AND A BRONCHOSCOPY WAS DONE TO LOOK FOR CANCER IN THE LEFT BRONCHIAL REGION, AND NONE WAS FOUND.

FURTHERMORE, ALL OF THE CT STUDIES AND ALL OF THE X-RAYS FAILED TO DEMONSTRATE ANY INVOLVEMENT OF THE LUNG AT ALL.

WELL, GIVEN THE FACT THAT THERE WAS SIMPLY NO RADIOGRAPHIC EVIDENCE AND THERE'S NO EVIDENCE FROM THE

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BRONCHOSCOPY THAT THE LUNG WAS INVOLVED, I WOULD HAVE TO SAY THAT, IN MY JUDGMENT, THE LUNG SIMPLY WASN'T INVOLVED.

Q. LET ME ASK YOU, DOCTOR: IN YOUR EXPERIENCE, HOW OFTEN DOES A BRONCHOSCOPY PROVIDE A POSITIVE BIOPSY IN CASES OF SMALL CELL CARCINOMA THAT BEGINS GROWING IN THE LUNG?

A. I CAN'T GIVE YOU AN EXACT FIGURE, BUT IN THE GREAT MAJORITY OF CASES, IT'S POSITIVE.

Q. IN YOUR EXPERIENCE, DOCTOR, HOW OFTEN DOES A CT SCAN OR AN X-RAY DEMONSTRATE INVOLVEMENT OF THE LUNG IN CASES IN WHICH A SMALL CELL CARCINOMA BEGINS GROWING IN THE LUNG?

A. WELL, WHAT THE CT AND X-RAYS DEMONSTRATE ARE MULTIPLE MASSIVELY ENLARGED LYMPH NODES. THEY'RE NOT VERY GOOD AT FINDING THE PRIMARY TUMOR IN CASES OF SMALL CELL CANCER, BUT THEY'RE VERY GOOD IN PICKING OUT LYMPH NODE INVOLVEMENT THAT MAY SUGGEST THE PRESENCE OF SUCH A CANCER.

Q. ARE THERE OTHER FINDINGS OR ABNORMALITIES THAT YOU'VE OBSERVED WITH ANY FREQUENCY FROM BRONCHOSCOPIES IN PATIENTS WHO HAVE A PRIMARY CARCINOMA THAT STARTS GROWING IN THE LUNG?

A. WOULD YOU REPEAT THE FIRST PART.

Q. YES. IN YOUR EXPERIENCE, DOCTOR, ARE THERE OTHER FINDINGS OR ABNORMALITIES THAT ARE TYPICALLY ASSOCIATED -- THAT CAN BE DEMONSTRATED BY BRONCHOSCOPY THAT ARE TYPICALLY ASSOCIATED WITH A SMALL CELL CARCINOMA THAT STARTS GROWING IN THE LUNG?

A. WELL, USUALLY, YOU CAN FIND THE PRIMARY TUMOR -- I MEAN, ORDINARILY, YOU FIND AN AREA WHERE THE BRONCHUS IS

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ULCERATED OR HAS A LITTLE THICKENING OF THE MUCUS MEMBRANE, THAT SORT OF THING.

AS I SAID, YOU KNOW, THE BIOPSY IS USUALLY POSITIVE.

Q. IS THERE ANY EVIDENCE OF THAT KIND OF ULCERATION

OR THICKENING IN THIS CASE?
A. NO, SIR. BUT ON THE OTHER HAND, WE NEVER GOT ANY TISSUE FROM THAT BRONCHIAL SITE. IT'S UNFORTUNATE THAT WE CAN'T ANSWER THAT QUESTION.
Q. DOCTOR, HOW OFTEN -- STRIKE THAT.
IN YOUR EXPERIENCE, IN CASES IN WHICH A SMALL CELL CARCINOMA IS DIAGNOSED TO HAVE STARTED GROWING IN THE LUNG, AT THE TIME IT'S DIAGNOSED, ARE THERE OTHER PARTS OF THE BODY TO WHICH IT'S TYPICALLY ALREADY SPREAD?
A. YES. IT MAY NOT BE IMMEDIATELY EVIDENT, BUT IT'S VERY COMMON TO FIND LYMPH NODE INVOLVEMENT IN THE CHEST, BUT ALSO ALONG THE UPPER AND LOWER BORDERS OF THE PANCREAS AND IN THE ADRENAL GLANDS.
SO IT'S CUSTOMARY WHEN YOU'RE MAKING A DIAGNOSIS ON SUCH A PATIENT TO LOOK AT THE CT'S FOR LESIONS IN THOSE LOCATIONS.
THAT WAS DONE IN THIS CASE, AND THERE WAS NO EVIDENCE OF NODAL METASTASES, NOR EVIDENCE OF INVOLVEMENT OF THE ADRENAL GLANDS IN THIS PATIENT.
Q. WHAT ARE SOME OF THE OTHER PARTS OF THE BODY WHERE A SMALL CELL CARCINOMA CAN START?
A. WELL, PRACTICALLY ANY EPITHELIAL ORGAN MAY BE THE SITE OF ORIGIN OF THE SMALL CELL CANCER. IF WE LOOK AT

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THOSE WHICH ARE DIFFICULT TO DIAGNOSE AND MAY BE CONFUSED WITH BRONCHOGENIC CARCINOMA, I WOULD SAY THE MOST COMMON IS CARCINOMA OF THE PANCREAS OF SMALL CELL TYPE.
THAT ORGAN, AS I MENTIONED BEFORE, IS SORT OF HIDDEN FROM VIEW. IT'S HARD TO GET A GOOD PICTURE OF THE PANCREAS. SO SOMETIMES IT FIRST PRESENTS AS METASTATIC DISEASE TO THE LYMPH NODES AND TO THE LUNG -- THE LYMPH NODES IN THE CHEST AND TO THE LUNG.
A TUMOR THAT HAS TO BE BROUGHT INTO QUESTION IN THIS PARTICULAR CASE IS THE RARE TUMOR KNOWN AS SMALL CELL CARCINOMA OF THE THYMUS GLAND.
Q. WHY IS IT THAT THAT'S A CONSIDERATION IN THIS CASE?
A. WELL, AS I SAID, THE SURGEON BIOPSIED THE MEDIASTINUM. THE FACT IS THE THYMUS GLAND IS LOCATED IN THE MEDIASTINUM. THE TISSUE THAT WE GOT CONTAINED ONLY FAT, NO EVIDENCE OF LYMPH NODE TISSUE.
AND THE THYMUS GLAND, IN PERSONS OF THIS LADY'S AGE, FREQUENTLY ARE COMPOSED CHIEFLY OF FAT AND OF FIBROUS TISSUE.
OTHER REASONS INCLUDE THE IMPORTANT CONSIDERATION THAT THIS WAS A SINGLE MASS, AT LEAST TO MY EYE, LOOKING AT THE CT, SOMEWHAT LOBULATED.
Q. CAN I ASK YOU TO EXPLAIN THAT.
WHAT DO YOU MEAN BY A "SINGLE MASS, SOMEWHAT LOBULATED"?
A. WELL, METASTATIC CANCER OF BRONCHOGENIC ORIGIN OF SMALL CELL TYPE --

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Q. LET ME INTERRUPT YOU THERE.
DO YOU MEAN A CANCER THAT HAD STARTED IN THE LUNG AND SPREAD SOMEWHERE ELSE?
A. YES. YES, SIR. I'M GLAD YOU CLARIFIED THAT.
WELL, AS I SAID BEFORE, IT SPREADS TO A NUMBER OF LYMPH NODES. SO USUALLY, WE'RE CONFRONTED WITH A FAIRLY LARGE NUMBER OF DISCRETE LYMPH NODES OR LYMPH NODES THAT ARE MATTED TOGETHER BECAUSE OF CANCER, BUT AT LEAST THEY'RE

SEPARATE LUMPS. THEY'RE MASSES.
BUT THYMIC LESIONS TEND TO BE SOLITARY, AND THEY'RE LOCATED IN ESSENTIALLY WHERE THIS LADY HAD HER MASS, NAMELY, THE MEDIASTINUM AND RETROSTERNAL -- THE RETROSTERNAL SPACE.

Q. TELL US WHAT YOU MEAN BY "THE RETROSTERNAL SPACE OF THE MEDIASTINUM."

A. WELL, YOU KNOW, YOUR BREASTBONE AND STERNUM GOES FROM ABOUT HERE TO ABOUT HERE (INDICATING). IT'S THE BONE, THE FIRM BONE THAT YOU CAN EASILY FEEL TO WHICH YOUR RIBS ARE ATTACHED.

THE RETROSTERNAL SPACE IS THAT SPACE JUST BEHIND THE STERNUM. AND IF YOU WANT TO FIND THE THYMUS GLAND IN THE HUMAN BEING, THAT IS PRECISELY WHERE YOU LOOK, BECAUSE THAT'S THE USUAL LOCATION OF THE THYMUS, BEARING IN MIND THAT IT CAN BE QUITE IRREGULARLY SHAPED AND IT CAN BE FAIRLY EXTENSIVE.

Q. NOW, IS THAT SPACE SOMETHING THAT'S IN THE LUNG?

A. NO, SIR.

Q. SEPARATE FROM THE LUNG?

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A. SEPARATE FROM THE LUNG.

Q. THERE HAS BEEN SOME DISCUSSION THIS MORNING AND EARLIER IN THE CASE ABOUT SOMETHING CALLED THE HILAR REGION.

IS THAT A PHRASE OR A TERM WITH WHICH YOU'RE FAMILIAR?

A. YES, SIR.

Q. WHAT IS THE HILAR REGION OF THE LUNG, OR ANY OTHER PART OF THE BODY?

A. WELL, THE WORD "HILUM" OR "HILUS" CAN BE DEFINED AS AN INDENTATION IN AN ORGAN THROUGH WHICH NOURISHING BLOOD VESSELS, IN THE CASE OF THE LUNG, THE WINDPIPE, ALSO PASSES.

THE HILUM IS NOT PART OF THE LUNG. IT'S A REGION WHERE THERE'S A DEPRESSION IN WHICH THE HEART SITS. AND THOSE BLOOD VESSELS GO IN AND OUT, AND THE MAIN STEM BRONCHUS GOES IN AND OUT.

AND THAT PARTICULAR REGION IS NOT COVERED BY THE GLISTENING TRANSPARENT MEMBRANE THAT WE CALL THE PLEURA. SO IT'S REALLY -- IT REALLY REFERS TO THE CONFIGURATION -- YOU COULD APPLY THE TERM "HILUM" TO THE INDENTATION OF A KIDNEY BEAN, AND IT'S APPLIED ANATOMICALLY TO THE INDENTATION OF THE KIDNEY.

I'M SURE MOST PEOPLE ARE FAMILIAR WITH THE KIDNEY, YOU KNOW THE KIDNEY. THAT IS KIND OF THAT SHAPE. ON ONE SIDE AND TOWARDS THE MIDDLE OF THE BODY, THERE IS AN INDENTATION WHERE THE RENAL ARTERY AND VEIN GOES THROUGH. WE CALL THAT THE HILUM OF THAT ORGAN.

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Q. AND THE MEDIASTINUM IS WHAT?

A. THAT'S A PLACE --

Q. WHERE IS IT?

A. WELL, THE MEDIASTINUM IS THAT PLACE BETWEEN THE LUNGS AND THE ROOT OF THE NECK, AND GOING DOWN TO THE DIAPHRAGM, THAT SEPARATES THE ABDOMEN FROM THE CHEST.

THAT SPACE IS FILLED UP WITH THE HEART AND THE GREAT VESSELS SPRINGING FROM THE HEART AND GOING TO THE HEART. AND IT ALSO CONTAINS, OF COURSE, THE ESOPHAGUS OR THE FOOD PIPE, AND THE TRACHEA AND BRONCHI IN THE UPPER PORTION.

Q. DEFENDANT'S EXHIBIT 2790 PREVIOUSLY ADMITTED INTO EVIDENCE, DOCTOR, IS THE X-RAY REPORT OF THE DEPARTMENT IMAGING SERVICES OF THE CT SCAN AND THE X-RAYS PERFORMED ON MS. HENLEY --

A. MM-HMM.

Q. -- IN JANUARY OF 1998.

IS THAT A RECORD YOU'VE PREVIOUSLY REVIEWED?

A. YES, I HAVE A FAIRLY GOOD RECOLLECTION OF IT.

Q. IN THAT REPORT, THERE IS A REFERENCE TO THE ABSENCE OF ADENOPATHY, A-D-E-N-O-A-P --

A. T-H-Y.

Q. -- T-H-Y.

WHAT IS ADENOPATHY?

A. WELL, SIR, IT MEANS SIMPLY DISEASE OF THE LYMPH NODES. BUT SPECIFICALLY, IN THE CONTEXT OF THE CHEST X-RAY OR A CT OF THE CHEST, IT MEANS THAT THE LYMPH NODES ARE NOT ENLARGED.

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THAT'S AN EXTREMELY IMPORTANT POINT IN THIS CASE. NOT ONLY IS THE MASS DESCRIBED TO BE MEDIASTINAL AND EXTENDING TOWARD THE HILUM OF THE LUNG, BUT FURTHERMORE, THE LYMPH NODES ARE NOT ENLARGED.

SO THIS ADDS STRENGTH TO THE HYPOTHESIS THAT THE TUMOR COULD HAVE ORIGINATED FROM THE THYMUS GLAND AS OPPOSED TO THE BRONCHUS.

Q. ARE THERE ANY OTHER FINDINGS OR CHARACTERISTICS OF MS. HENLEY'S SITUATION THAT COMPARE OR CONTRAST TO A TYPICAL CANCER THAT BEGINS GROWING IN THE LUNG OTHER THAN THE ONES YOU'VE ALREADY MENTIONED?

A. NONE THAT I CAN THINK OF AT THIS MOMENT. I'M PROBABLY OVERLOOKING SOMETHING. BUT FROM MY STANDPOINT AS A PATHOLOGIST, I THINK WE'VE COVERED THE DIFFERENCES OF ANATOMY.

Q. DOCTOR, LET ME ASK YOU TO ASSUME THAT THERE HAS BEEN TESTIMONY IN THIS CASE THAT MOST OF THE TIME WHEN A PATIENT IS DISCOVERED TO HAVE A SMALL CELL CARCINOMA, IT TURNS OUT TO HAVE STARTED IN THE LUNG.

DOESN'T THAT -- OR DOES THAT SUGGEST TO YOU THAT THIS IS A TUMOR THAT PROBABLY STARTED IN MS. HENLEY'S LUNG, EVEN THOUGH IT WASN'T FOUND IN THE BRONCHOSCOPY OR DEMONSTRATED ON THE X-RAY?

A. NO, ABSOLUTELY NOT.

Q. WHY NOT?

A. WELL, AS I SAID AT THE VERY BEGINNING, WE PATHOLOGISTS HAVE TO HAVE AN INDEPENDENT JUDGMENT OF THE MATERIAL THAT WE HAVE IN HAND TO EVALUATE, AND WE HAVE TO BE

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VERY OBJECTIVE. WE CAN'T PLAY THE ODDS.

YOU KNOW, PLAYING THE ODDS MAY BE OKAY FOR RECREATION, BUT NOT FOR DIAGNOSIS OF DISEASE IN A HUMAN BEING. OUR OBLIGATION IS TO LOOK FOR THE EVIDENCE AND TO INTERPRET IT. I CAN'T INTERPRET THE ODDS IN A PARTICULAR CASE.

Q. IN ORDER TO TREAT A PATIENT IN MS. HENLEY'S SITUATION, IS IT TYPICALLY NECESSARY TO DETERMINE PRECISELY WHERE A CANCER OF THIS TYPE STARTED GROWING IN THE BODY?

A. WELL, THERE ARE TWO WAYS OF LOOKING AT THAT QUESTION, BEFORE AND AFTER THE FACT OF DIAGNOSIS AND TREATMENT.

I WOULD SAY THAT UP TO THE MOMENT YOU INITIATE TREATMENT, YOU WANT TO MAKE AN EFFORT TO FIND OUT WHAT THE

CELL TYPE IS AND WHERE THE TUMOR ORIGINATED FROM, SO THAT YOU CAN BE SURE THAT YOU SELECT THE RIGHT TREATMENT FOR THE PATIENT.

IN THIS PARTICULAR CASE, WHERE IT'S BEEN ESTABLISHED THAT SHE IS DEALING WITH A SMALL CELL CARCINOMA, IT'S KIND OF AN ACADEMIC POINT WHETHER IT ORIGINATED IN THE LUNG OR THE THYMUS FROM THE STANDPOINT OF THERAPY.

AS FAR AS WE KNOW TODAY, THE TREATMENT OF THE TWO CANCERS WOULD BE EXACTLY THE SAME.

Q. AND IN NEITHER CASE WOULD SURGERY OR REMOVAL OF THE TUMOR BE AN OPTION?

A. NO, I DON'T THINK THAT WOULD BE INDICATED.

MR. OHLEMEYER: ALL RIGHT. MAY I HAVE A MOMENT, YOUR HONOR?

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THE COURT: YES. WE'RE GOING TO TAKE OUR MORNING RECESS ANYWAY.

DO YOU WANT TO DO IT NOW?

MR. OHLEMEYER: THAT'S FINE.

THE COURT: OKAY. JURORS, LET'S TAKE A 15-MINUTE RECESS UNTIL 11:30. PLEASE CONTINUE TO FOLLOW THE ADMONITION. WE'LL SEE YOU BACK AT 11:30.

(RECESS TAKEN FROM 11:15 TO 11:30 A.M.)

THE COURT: OKAY. WE'RE BACK ON THE RECORD.

MR. OHLEMEYER.

MR. OHLEMEYER: JUST A FEW MORE QUESTIONS.

Q. DR. HENSLEY, I WANT TO MAKE SURE I'VE GOT SOME TERMS STRAIGHT.

YOU MENTIONED EARLIER SOMETHING CALLED "BRONCHOGENIC CARCINOMA OF THE LUNG."

A. YES, SIR.

Q. AND IS THAT A TYPE OF CANCER THAT STARTS -- WELL, IS THAT A TYPE OF LUNG CANCER?

A. YES, SIR, IT IS.

Q. WHERE IN THE LUNG DOES THAT TYPE OF CANCER START?

A. WELL, IT STARTS IN THE LARGER AIRWAYS DERIVED FROM THE TRACHEA OR WINDPIPE, AS THEY GO INTO THE LUNG.

Q. ARE THOSE KNOWN AS BRONCHUS?

A. YES, SIR. THE PLURAL IS BRONCHI, B-R-O-N-C-H-I.

THERE ARE TUBES THAT GO DOWN TO THE SIZE OF MAYBE AROUND TWO MILLIMETERS. BRONCHOGENIC CARCINOMA ORIGINATE FROM THEM.

Q. ARE THOSE THE TUBES, THE BRONCHI, THAT THE

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BRONCHOSCOPY OR THE BRONCHOSCOPE IS INSERTED INTO WHEN A BRONCHOSCOPY IS PERFORMED?

A. YES.

Q. IS SMALL CELL CARCINOMA OF THE LUNG -- STRIKE THAT.

WHEN SMALL CELL CARCINOMA OF THE LUNG IS DIAGNOSED, HOW OFTEN IS IT DIAGNOSED AS AN ENDOBRONCHIAL LESION?

A. IT'S USUALLY AN ENDOBRONCHIAL LESION. PERHAPS, IN FACT, ONE CAN SAY THAT SMALL CELL ANAPLASTIC CARCINOMA ALWAYS ORIGINATES FROM THE MUCUS MEMBRANE OF THE BRONCHUS, SO THAT IN FACT ALL ARE IN THAT LOCATION.

NOW, THEY MAY BE OVERLOOKED IF THEY'RE OUT TOO FAR FOR THE BRONCHOSCOPE TO PENETRATE TO OR IF THE ORIGINAL LESION IS VERY SMALL.

Q. BY THE WAY, WHEN WE TALK ABOUT SMALL CELL CARCINOMA, DOES THAT REFER TO THE SIZE OF THE TUMOR?

A. NO, SIR. I REGRET TO SAY IT DOES NOT NECESSARILY REFLECT THE SIZE OF EITHER THE TUMOR OR THE CELLS THAT COMPOSE IT.
Q. SO IT CAN BE A MISNOMER IN TERMS OF SIZE?
A. IT IS A MISNOMER THAT IS USED FOR HISTORICAL REASONS.
Q. AND THEN WOULD YOU DEFINE FOR ME OR EXPLAIN FOR US WHAT THE PHRASE "CLINICAL PRESENTATION" MEANS.
A. WELL, "CLINICAL PRESENTATION" MEANS THE SIGNS OR SYMPTOMS THAT BRING THE PATIENT TO THE ATTENTION OF A PHYSICIAN.

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Q. DO THEY INCLUDE THE WORKUP THAT'S SUBSEQUENTLY DONE AFTER THE PATIENT SEES THE DOCTOR?
A. WELL, NOT STRICTLY SPEAKING. I SUPPOSE SOME PEOPLE COULD USE THE TERM THAT WAY, BUT STRICTLY SPEAKING, IT'S THE SIGNS AND SYMPTOMS THAT THE DOCTOR IS PRESENTED WITH INITIALLY WHEN HE SEES THE PATIENT.
Q. DOCTOR, TAKING INTO ACCOUNT MS. HENLEY'S CLINICAL PRESENTATION, THE X-RAYS, THE CT SCANS, THE RESULTS OF THE BRONCHOSCOPY AND THE BIOPSY OBTAINED THROUGH THE MEDIASTINOTOMY, IS THAT -- YOU'VE CONSIDERED ALL OF THAT IN FORMING YOUR OPINION?
A. YES, SIR, I HAVE.
Q. IN YOUR EXPERIENCE AS A PATHOLOGIST, IS ALL OF THAT INFORMATION COLLECTIVELY TYPICAL OF A PATIENT WHO HAS A SMALL CELL CARCINOMA THAT BEGINS GROWING IN THE LUNG?
A. NO, SIR, IT IS NOT.
MR. OHLEMEYER: THANK YOU, DOCTOR. THOSE ARE ALL THE QUESTIONS I HAVE.
THE COURT: MS. CHABER.

CROSS-EXAMINATION

BY MS. CHABER: Q. GOOD MORNING, DR. HENSLEY.
A. GOOD MORNING.
Q. YOU AND I HAVE MET ONCE BEFORE?
A. YES. NICE TO SEE YOU AGAIN.
Q. I TAKE IT YOUR EYES ARE BETTER?
A. MUCH BETTER.
Q. GOOD. GLAD TO HEAR THAT.

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DR. HENSLEY, YOU WROTE NOTES IN THIS CASE, DIDN'T YOU?
A. YES.
Q. NOW, LET ME UNDERSTAND THE ORIGIN OF YOUR GETTING INVOLVED IN THIS CASE.
YOU HAVE DONE WORK IN THE PAST ON BEHALF OF CIGARETTE COMPANIES IN THEIR DEFENSE OF CASES; CORRECT?
A. WELL, MORE PRECISELY STATED, I'M CONSULTED BY SHOOK, HARDY & BACON, WHICH DOES REPRESENT SOME CIGARETTE COMPANIES, BUT I DON'T EVEN KNOW WHICH ONES THEY ARE.
Q. YOU UNDERSTAND, THOUGH, WHEN SHOOK, HARDY & BACON IS CONTACTING YOU, THAT THEY ARE CONTACTING YOU WITH RESPECT TO THEIR DEFENSE IN A CASE WHERE AN INDIVIDUAL OR INDIVIDUALS ARE ALLEGING THAT THEY HAVE BEEN HARMED BY CIGARETTE SMOKE?
A. YES, MA'AM.
Q. AND YOUR INVOLVEMENT WITH SHOOK, HARDY & BACON, THIS IS NOT THE FIRST TIME THAT YOU WERE INVOLVED WITH THEM; CORRECT?
A. NO. IT'S THE FIRST TIME I'VE TESTIFIED FOR THEM,

BUT I HAVE BEEN INVOLVED WITH THEM PREVIOUSLY.
Q. AND YOU'VE CONSULTED ON CASES BEFORE WITH THEM?
A. YES, MA'AM.
Q. AND YOU HAVE BEEN DEPOSED, WHERE YOU'RE ASKED QUESTIONS OUTSIDE OF THE COURTROOM UNDER OATH; CORRECT?
A. YES.
Q. AND IN FACT, RECENTLY, YOU'VE BEEN DEPOSED IN A CASE CALLED ENGLE, E-N-G-L-E?

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A. YES.
Q. AND THAT'S A CLASS ACTION --
MR. OHLEMEYER: EXCUSE ME, YOUR HONOR. I OBJECT TO THIS AS IMPROPER CROSS-EXAMINATION.
MS. CHABER: IT GOES TO --
THE COURT: THE DETAILS OF THE CASE ARE NOT IMPORTANT.
MS. CHABER: Q. YOU UNDERSTAND THAT YOUR ROLE IN ENGLE RELATES TO MANY PEOPLE ALLEGING INJURY FROM CIGARETTE SMOKE; CORRECT?
MR. OHLEMEYER: SAME OBJECTION.
THE COURT: THAT IS THE SAME QUESTION I JUST SUSTAINED AN OBJECTION TO.
MS. CHABER: I'M JUST DISTINGUISHING THAT IT'S NOT AN INDIVIDUAL CASE.
THE COURT: DON'T ARGUE. I HAVE SUSTAINED THE OBJECTION TWICE NOW. JUST DON'T ASK THE SAME QUESTION AGAIN.
YOU CAN ASK ANOTHER ONE.
MS. CHABER: Q. DOCTOR, YOU HAVE DONE WORK FOR SHOOK, HARDY & BACON IN CASES WHERE PEOPLE HAVE ALLEGED BUERGER'S DISEASE; CORRECT?
A. I DON'T KNOW.
NO, NOT DIRECTLY. WE HAVE DISCUSSED BUERGER'S DISEASE, BUT I'VE NEVER BEEN PRESENTED WITH, SO FAR AS I KNOW, SPECIFIC ALLEGATIONS OF BUERGER'S DISEASE.
Q. YOU UNDERSTAND THAT THAT'S ONE OF THE ALLEGATIONS IN THIS ENGLE CASE, DON'T YOU?

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MR. OHLEMEYER: YOUR HONOR --
THE COURT: SUSTAINED.
THE WITNESS: I'M NOT SURE.
THE COURT: SUSTAINED.
MS. CHABER: Q. NOW, YOUR WRITINGS, NOTES IN THIS CASE, THAT'S NOT UNUSUAL FOR A DOCTOR TO DO, IS IT?
A. NOT AT ALL.
Q. IN FACT, WHEN YOU LOOK AT PATHOLOGY MATERIALS, YOU PROBABLY TAKE NOTES REGULARLY; CORRECT?
A. DEPENDING ON THE PURPOSE, YES.
Q. AND IS IT FAIR TO SAY THAT, GENERALLY, YOU WRITE UP SOME KIND OF A REPORT?
A. WELL, ACTUALLY, NO. IN THE CASE OF CONSULTATIONS OF THIS TYPE, WHAT I SIMPLY DO IS WRITE A SERIES OF NOTES WHICH ARE MEANT TO JOG MY MEMORY ABOUT SPECIFIC SLIDES, AND I WILL LIST A DIAGNOSIS, BUT I DON'T ACTUALLY WRITE A REPORT.
Q. YOU'RE RETIRED NOW; CORRECT?
A. YES, MA'AM.
Q. WHEN YOU WERE PRACTICING, AS A PRACTICING PATHOLOGIST, IT WAS YOUR REGULAR CUSTOM TO WRITE NOTES AND WRITE REPORTS; CORRECT?
A. WELL, NOT PRECISELY. WHEN I WAS DOING DIAGNOSTIC

WORK AT THE UNIVERSITY, I WAS WORKING WITH GRADUATE STUDENTS WHO WERE STUDYING PATHOLOGY, PHYSICIANS WHO WOULD SIT DOWN WITH ME AT THE MICROSCOPE AND DISCUSS THE CASES.
AND WE WOULD ARRIVE AT AN OPINION. AND THEY WOULD MAKE NOTES, AND THEY WOULD BE RESPONSIBLE FOR

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DICTATING THE REPORT, WHICH I SUBSEQUENTLY WOULD READ AND SIGN.
BUT I DIDN'T ACTUALLY DO THAT OVER THE PAST 20 YEARS, BECAUSE I HAD OTHERS TO DO IT FOR ME.
Q. BUT SOMEBODY WAS WRITING A REPORT?
A. ABSOLUTELY.
Q. AND YOU IN FACT WOULD REVIEW IT AND HAVE TO SIGN OFF ON IT; CORRECT?
A. ABSOLUTELY.
Q. AND IN THIS CASE, WHEN YOU WERE ASKED TO BE INVOLVED IN MS. HENLEY'S CASE, YOU DID NOT PREPARE A REPORT; CORRECT?
A. YES. I'VE ALREADY SAID THAT, I BELIEVE.
Q. NO ONE ELSE PREPARED A REPORT FOR YOU TO REVIEW AND SIGN, DID THEY?
A. OH, NO.
Q. AND WHEN YOU FIRST WERE ASKED TO BE INVOLVED IN MS. HENLEY'S CASE, THREE LAWYERS CAME TO MEET WITH YOU?
A. WELL, I DON'T REALLY RECALL HOW MANY THERE WERE. I RECALL THAT SOMETIME IN THE AUTUMN OF LAST YEAR, I MET WITH ONE OR MORE PEOPLE FROM THE FIRM WHO BROUGHT ME THOSE SLIDES.
Q. YES.
IN FACT, YOU WEREN'T SENT THE SLIDES. THE LAWYERS ACTUALLY CAME AND BROUGHT YOU THE SLIDES; RIGHT?
A. TO MY OFFICE.
Q. AND YOU LOOKED AT THE PATHOLOGY SLIDES WITH THE LAWYERS; CORRECT?

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A. WITH THE LAWYERS PRESENT.
Q. AND WHEN YOU'VE BEEN INVOLVED IN THE PAST WITH SHOOK, HARDY & BACON, THERE'S A PARTICULAR LAWYER THAT IS RESPONSIBLE FOR DEALING WITH YOU; CORRECT?
A. NOT A SPECIFIC INDIVIDUAL.
Q. MR. SIRRIDGE ISN'T THE INDIVIDUAL WHO DEALS WITH YOU?
A. NO, MA'AM.
Q. HE IS SOMEONE WHO HAS DEALT WITH YOU?
A. YES, BUT HE'S NEVER BROUGHT SLIDES TO MY OFFICE, AND THAT'S THE WAY I CONSTRUED YOUR QUESTION.
Q. NONE OF THE LAWYERS THAT ARE SITTING HERE AT COUNSEL TABLE ARE THE ONES THAT BROUGHT THE SLIDES TO YOU, ARE THEY?
A. NONE OF THEM, NO.
Q. NOW, IN ADDITION TO REVIEWING THE MEDICAL RECORDS IN THIS CASE AND LOOKING AT THE SLIDES, YOU ALSO REVIEWED SOME REPORTS THAT WERE PREPARED IN THIS CASE BY OTHER PEOPLE INVOLVED; CORRECT?
A. FROM THE MEDICAL RECORDS.
Q. WERE YOU GIVEN A 14-PAGE REPORT PREPARED BY DR. HORN TO REVIEW?
A. NO.
Q. WERE YOU GIVEN A FOUR-PAGE REPORT PREPARED BY DR. HAMMAR TO REVIEW?
A. NO.

Q. WERE YOU GIVEN A 30-PAGE REPORT BY DR. FEINGOLD TO REVIEW?

A. NO.
Q. NOW, YOU'D AGREE, WOULD YOU NOT, SIR, THAT IN REVIEWING THE MEDICAL RECORDS, THE CONSENSUS OF MS. HENLEY'S TREATING PHYSICIANS WAS THAT SHE HAD SMALL CELL CARCINOMA OF THE LUNG?
A. YES.
Q. AND YOU WOULD AGREE THAT THE PEOPLE WHO ARE CHARGED WITH HER TREATMENT AND HER CARE AT THE PRESENT TIME HAVE DIAGNOSED SMALL CELL CARCINOMA OF THE LUNG?
A. WELL, I'M NOT SURE OF THAT FACT. I HAVE LOOKED AT THE MEDICAL RECORDS UP TO A POINT, AND I DON'T KNOW TO WHOM YOU'RE REFERRING.
Q. YOU LOOKED AT DR. RAUL MENA'S RECORDS, DIDN'T YOU?
A. I DON'T RECALL THE NAME, BUT I MAY HAVE REVIEWED THE RECORDS AND JUST MAY HAVE A FAULTY MEMORY.
Q. AND HAVE YOU CALLED ANY OF HER TREATING PHYSICIANS TO TELL THEM THAT THEIR DIAGNOSIS IS INCORRECT?
A. NO.
Q. HAVE YOU -- NOW, LET ME UNDERSTAND --
MR. OHLEMEYER: EXCUSE ME, YOUR HONOR.
THE WITNESS: MAY I ADD SOMETHING TO THAT?
MS. CHABER: Q. SURE.
A. WE'RE TALKING ABOUT PROFESSIONAL OPINIONS. WE'RE NOT TALKING ABOUT WHAT IS RIGHT AND WHAT IS WRONG.
I WOULDN'T PRESUME TO CALL THOSE PHYSICIANS AND TELL THEM, "HEY, YOU'RE WRONG AND I'M RIGHT." I MIGHT TALK WITH THEM AND DISCUSS THE REASONS FOR MY OPINION, BUT

THERE'S NO REASON THAT I WOULD PICK UP THE TELEPHONE AND CALL SOMEBODY AND SAY "YOU'RE WRONG" IN A CASE LIKE THIS.
Q. YOU'D ASSUME IT WOULD BE IMPORTANT FOR THE TREATING PHYSICIANS TO KNOW THAT THEY HAD THE CORRECT DIAGNOSIS, DON'T YOU?
A. NO. AT THIS POINT, IT DOESN'T MAKE MUCH DIFFERENCE. THE CHEMOTHERAPY AND THE RADIATION USED FOR THE TWO NEOPLASMS IN QUESTION HAPPEN TO BE THE SAME.
THAT MAKES IT UNIMPORTANT TO CLARIFY IT WITH RESPECT TO THE TREATMENT IN QUESTION.
Q. NOW, WITH RESPECT TO DR. MENA, THE PERSON WHO ADMINISTERED TREATMENT TO HER, WERE YOU PROVIDED WITH HIS TESTIMONY AND HIS STATEMENT THAT IF HE THOUGHT THIS WAS A THYMIC CANCER, HE WOULD HAVE WANTED TO DO LITERATURE REVIEWS WITH RESPECT TO THE CORRECT CHEMOTHERAPY AND RADIATION?
MR. OHLEMEYER: YOUR HONOR, I OBJECT TO THE QUESTION AS BEING ARGUMENTATIVE.
THE COURT: WELL, IS YOUR OBJECTION THAT IT MISCHARACTERIZES THE EVIDENCE?
MR. OHLEMEYER: FIRST OF ALL --
THE COURT: IT'S NOT ARGUMENTATIVE.
MR. OHLEMEYER: FIRST OF ALL, THE WITNESS --I DON'T WANT TO SPEAK OUT OF TURN. YOU HAVE INVOKED THE RULE.
THE WITNESS COULDN'T HAVE READ DR. MENA'S TRIAL TESTIMONY, SO IT'S AN ARGUMENTATIVE QUESTION.
THE COURT: ALL RIGHT. I WILL SUSTAIN.
MS. CHABER: Q. DR. HENSLEY, YOU HAVE NO

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CRITICISMS OF THE CARE OR TREATMENT THAT MS. HENLEY RECEIVED; CORRECT?

A. NO.

Q. AND YOU HAVE NO CRITICISMS THAT HER DOCTORS WHO WERE MAKING DIAGNOSES ABOUT HER WERE INCOMPETENT?

A. OF COURSE NOT.

Q. AND I THINK YOU SAID THAT IF IT'S NOT A LUNG CANCER, IT'S A THYMIC CANCER.

IS THAT WHAT YOUR OPINION IS, SIR?

A. NO. MORE PRECISELY, MY OPINION IS THAT THE WEIGHT OF EVIDENCE INDICATES THIS IS MORE LIKELY TO BE A CANCER ORIGINATING FROM THE THYMUS GLAND THAN FROM THE LUNG.

Q. AND THAT WOULD BE A THYMIC CANCER; CORRECT?

A. I BELIEVE I SAID THAT.

Q. SO IN YOUR DIFFERENTIAL DIAGNOSIS, THE NO. 1 THING YOU'D CONSIDER IS THYMIC CANCER; CORRECT?

A. IN THIS PARTICULAR CASE.

Q. AND YOU UNDERSTAND, DON'T YOU, SIR, THAT A SMALL CELL TYPE OF THYMIC CANCER IS EXCEEDINGLY RARE?

A. OF COURSE.

Q. AND YOU'VE NEVER DIAGNOSED A PRIMARY THYMIC SMALL CELL CANCER, HAVE YOU?

A. NO.

Q. IN FACT -- STRIKE THAT.

YOU'D AGREE THAT A DOCTOR MAKING A DIAGNOSIS, BEFORE THEY MAKE THE FINAL JUDGMENT CALL, THEY NEED TO ADDRESS THE QUESTION OF PROBABILITIES?

A. IF THERE ISN'T ANY ALTERNATIVE, PROBABILITIES MAY

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BE REASONABLY CONSIDERED IN A DIAGNOSIS.

BUT OF COURSE, AS I SAID PREVIOUSLY, IN MEDICINE, WE DON'T LIKE TO USE HOW PROBABLE IT IS SOMEBODY HAS CANCER, BUT TO LOOK FOR DEFINITE EVIDENCE.

PROBABILITIES ARE NOT TERRIBLY RELIABLE, FROM MY STANDPOINT.

Q. DOCTOR, DO YOU RECALL BEING DEPOSED BY ME?

A. YES.

Q. AND DO YOU RECALL, IN YOUR DEPOSITION, SAYING THAT BEFORE A DOCTOR MAKES A FINAL JUDGMENT CALL, HE HAS TO TAKE THE PROBABILITIES INTO CONSIDERATION?

A. I DON'T RECOGNIZE THE CONTEXT.

WOULD YOU MIND SHOWING ME? I'M SURE I SAID THAT, IF YOU SAY IT, BUT I JUST DON'T RECOGNIZE THE CONTEXT.

Q. I'LL FIND IT IN A MINUTE.

DOCTOR, DO YOU RECALL BEING ASKED THE QUESTION: WHAT ARE THE FEATURES OF ANAPLASTIC CARCINOMA THAT ARE CONSISTENT WITH A THYMIC ORIGIN, GENERALLY?

A. YES.

Q. AND YOU INDICATED THAT THERE ARE NO MICROSCOPIC FEATURES THAT WOULD DISTINGUISH A SMALL CELL ANAPLASTIC CARCINOMA ORIGINATING IN ANY ONE PLACE FROM ANOTHER PLACE? DO YOU RECALL SAYING THAT?

A. YES, I SAID THAT.

Q. AND DO YOU RECALL SAYING THAT THEY ALL LOOK THE SAME, THAT THEY'RE ALL IDENTICAL?

A. I DID SAY THAT.

Q. AND YOU RECALL SAYING THAT THE DIAGNOSIS THEN HAS

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TO BE MADE LOOKING AT THE GROSS ANATOMICAL FEATURES; CORRECT?

A. YES.
Q. AND COMPARING ORGANS TO SEE WHICH ARE MOST LIKELY TO BE THE SITE OF ORIGIN OF A PARTICULAR TUMOR IN QUESTION?
A. YES.
Q. AND THEN TO CAREFULLY ADDRESS THE QUESTION OF PROBABILITIES BEFORE YOU MAKE A FINAL JUDGMENT CALL. DO YOU RECALL SAYING THAT?
A. I THINK THERE'S A TYPO THERE. I BELIEVE WHAT I SAID IS "PROBABILITY," NOT "PROBABILITIES."
IF I DIDN'T CATCH THAT IN A CORRECTION, I SHOULD HAVE.
Q. YOU DID MAKE CORRECTIONS TO YOUR DEPOSITION, DIDN'T YOU?
A. YES, BUT I DID NOT MEAN TO IMPLY THAT WE'RE TALKING ABOUT STATISTICAL PROBABILITIES.
I WAS TRYING TO IMPLY THAT WE'RE TALKING ABOUT WHAT IS MORE PROBABLE IN THE DIFFERENTIAL DIAGNOSIS. IS IT MORE LIKELY THAT A IS CORRECT OR B IS CORRECT.
Q. DID YOU SEE ANYWHERE IN MS. HENLEY'S MEDICAL RECORDS THAT ONE SINGLE ONE OF HER DOCTORS WHO WERE INVOLVED IN THE DIAGNOSIS, TREATMENT OR CARE OF HER HAD, AS PART OF THEIR DIFFERENTIAL DIAGNOSIS, A THYMIC SMALL CELL CANCER?
A. NO.
Q. AND SIR, YOU WOULD AGREE, WOULD YOU NOT, THAT ON THE PROBABILITY SCALE OF LUNG CANCER VERSUS THYMIC CANCER, THAT THERE'S LESS THAN A .15 PERCENT PROBABILITY OF A SMALL

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CELL CANCER BEING THYMIC VERSUS A LUNG CANCER?
A. AS I EXPLAINED, I DON'T THINK THAT'S RELEVANT. THE PROBABILITY THAT I WAS TALKING ABOUT IS WHETHER IT'S MORE PROBABLE THAT THIS PARTICULAR TUMOR ORIGINATED IN THE LUNG THAN IN THE THYMUS.
AND I TRIED TO SETTLE THAT ISSUE NOT BASED ON THE STATISTICAL ODDS BUT BY THE ANATOMICAL EVIDENCE AVAILABLE TO ME.
Q. LET'S LOOK AT THE LIKELIHOOD, DOCTOR, OF A THYMIC CANCER. LET'S TALK FOR A MOMENT, EVEN THOUGH THAT'S NOT WHAT YOU MEANT BY THAT, ABOUT PROBABILITIES.
DO YOU KNOW HOW MANY LUNG CANCERS THERE ARE IN ANY GIVEN YEAR IN THE UNITED STATES?
A. OH, I KNOW THAT FROM TIME TO TIME WHEN I LOOK IT UP, BUT I CERTAINLY DON'T REMEMBER IT.
I WOULD CERTAINLY AGREE WITH YOU THAT THE RATIO OF LUNG CANCER TO THYMIC CANCER IS SKEWED VERY, VERY HEAVILY IN FAVOR OF LUNG CANCER.
Q. AND IN FACT, IN 1999, THE PROJECTIONS -- YOU KNOW WHAT THE SEER DATA IS, DON'T YOU?
A. YES.
Q. AND THE SEER DATA IS DATA THAT IS COLLECTED WITH RESPECT TO THE ORIGINS, THE SITES OF CANCERS?
A. YES, BUT YOU HAVE TO REMEMBER THAT THESE DATA ARE DERIVED FROM RECORDS AND THE VALIDITY OF THE DATA MIGHT BE SLIGHTLY IN QUESTION.
NEVERTHELESS, I'M NOT GOING TO DISPUTE IN ANY WAY THE VALIDITY. I'M JUST POINTING OUT THAT THE NUMBERS GIVEN

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ARE NOT ABSOLUTELY CORRECT, BUT THEY'RE REASONABLE ESTIMATES.
Q. AND SO 180,000 CANCERS -- EXCUSE ME -- 180,000 CANCER DEATHS ARE NOTED ORIGINATING IN THE LUNG.
YOU WOULDN'T DISAGREE WITH THOSE NUMBERS?

A. NO.
Q. AND OF THE TYPES OF LUNG CANCER, ABOUT 20 TO 25 PERCENT OF LUNG CANCER TYPE ARE SMALL CELL?
A. APPROXIMATELY.
Q. AND DO YOU KNOW HOW MANY DEATHS THERE ARE FROM THYMIC CANCERS OR THE INCIDENCE OF THYMIC CANCERS?
A. I HAVEN'T LOOKED UP THAT DATA, BUT IT MUST BE A VERY SMALL NUMBER, BECAUSE THOSE CANCERS ARE RARE.
Q. LESS THAN 100?
A. WELL, WHEN YOU TALK ABOUT THESE NUMBERS, YOU HAVE TO REALIZE THAT -- LESS THAN 100? WELL, THAT'S A NUMBER OF CASES THAT WERE RECOGNIZED, BUT THEN HOW MANY WERE NOT RECOGNIZED? SO THAT'S AN ESTIMATE. IT'S REASONABLE.
AND I GUESS I COULD AGREE TO TALK ABOUT IT, BUT I COULDN'T SAY IT'S 100 PERCENT ACCURATE.
Q. AND THE NUMBER OF THYMIC CANCERS, HOWEVER SMALL, THAT IS EVEN SMALLER IF YOU LOOK AT THE CELL TYPE, SMALL CELL CANCER; CORRECT?
A. ABSOLUTELY.
Q. SO WE'RE TALKING ABOUT A RARE CELL TYPE OF A RARE DISEASE?
A. WHICH, TO ME, HAS LITTLE TO DO WITH MS. HENLEY. I DON'T WANT TO MAKE A DIAGNOSIS ON HER BASED ON ODDS. I'D

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RATHER DO IT ON THE BASIS OF THE ANATOMY OF MS. HENLEY.
Q. AND IN YOUR OPINION, SINCE MS. HENLEY WOULD BE CLASSIFIED AS A LUNG CANCER FOR SEER DATA, THAT WOULD BE A MISCLASSIFICATION; CORRECT?
A. SURE. AND THERE ARE MANY MISCLASSIFICATIONS IN ANY LARGE SERIES.
Q. SO IT WOULD BE REALLY IMPORTANT TO HAVE THE DIAGNOSIS BE CORRECT SO THAT THE STATISTICS THAT ARE BEING KEPT ARE ACCURATE, WOULDN'T IT?
A. WELL, MA'AM, I'VE ALREADY SAID, I'M NOT EXACTLY SITTING HERE SAYING THAT I'M AN ARBITER OF WHAT IS EXACTLY RIGHT AND EXACTLY WRONG. THE BEST I CAN DO FOR ANYBODY IS TO GIVE THEM MY BEST PROFESSIONAL OPINION.
I HAVE MY OPINION, WHICH DIFFERS FROM THE TESTING FIGURES AND WHAT IS IN THAT SERIES, BUT I DON'T FEEL IMPELLED TO GO OUT AND TRY TO CORRECT THE RECORD.
Q. AND YOU KNOW WHO DR. HAMMAR IS, DON'T YOU? YOU'VE HEARD OF HIM?
A. ONLY VERY SUPERFICIALLY.
Q. OKAY. YOU'RE FAMILIAR WITH THE TEXTBOOKS THAT HE'S WRITTEN?
A. WELL, I WOULDN'T SAY I'M CONVERSANT WITH HIS TEXTBOOKS. I KNOW HE'S WRITTEN.
Q. AND IT WAS DR. HAMMAR'S OPINION IN THIS COURTROOM THAT THE TUMOR WAS NOT GROWING INTO THE LUNG BUT RATHER EXTENDING IN THE OTHER DIRECTION?
MR. OHLEMEYER: YOUR HONOR. IT'S ARGUMENTATIVE.
THE WITNESS: I WOULD --

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THE COURT: JUST A SECOND. THERE IS AN OBJECTION.
MR. OHLEMEYER: OBJECTION. IT'S ARGUMENTATIVE.
THE COURT: IT'S AN INAPPROPRIATE FORM FOR A QUESTION.
SUSTAINED.
MS. CHABER: Q. I WANT YOU TO ASSUME THAT THERE'S BEEN TESTIMONY IN THIS COURTROOM THAT, RATHER THAN

WHAT I BELIEVE YOU SAID THE TUMOR WAS -- LET ME FIND WHAT YOU SAID.

THE COURT: WHILE YOU ARE LOOKING FOR THAT, LET ME ASK YOU A SCHEDULING ISSUE, MS. CHABER. IF WE STAY FOR A FEW MINUTES, ARE WE LIKELY TO FINISH WITH THE DOCTOR BEFORE LUNCH OR NOT?

MS. CHABER: IF WE STAYED FOR MAYBE 15 MINUTES, BUT NOT JUST ONE OR TWO, I COULD PROBABLY DO IT.

THE COURT: LET ME ASK THE JURY: ARE THERE ANY OF YOU THAT WOULD BE INCONVENIENCED IF WE WENT FOR ABOUT 15 MORE MINUTES? WOULD THAT INTERFERE WITH ANYBODY'S LUNCH PLANS? TATSUO OR JUDITH, EITHER OF YOU? YOU'RE BOTH OKAY WITH THAT?

ALL RIGHT. EVERYBODY HAS INDICATED THEY ARE OKAY. WHY DON'T WE PUSH FORWARD ON THIS.

AND AGAIN, I MIGHT HAVE THE JURY TAKE A LITTLE SHORTER OF A LUNCH TODAY, TO MAKE UP FOR SOME OF THE TIME THEY LOST THIS MORNING.

MS. CHABER: Q. LET ME ASK YOU ANOTHER QUESTION. I BELIEVE I HEARD THIS CORRECTLY ON DIRECT, BUT I

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WANT TO MAKE SURE.

DID YOU SAY THAT YOU DO NOT KNOW HOW A THYMIC CANCER SPREADS?

A. NO, I DON'T THINK I SAID THAT.

Q. OKAY.

A. I CERTAINLY DIDN'T INTEND TO.

Q. DO YOU KNOW HOW A THYMIC CANCER SPREADS?

A. WELL, THAT IS A VERY GENERAL QUESTION. AND YOU HAVE TO SAY THAT THE LOW-GRADE THYMIC CANCERS LOCALLY INVADE THE MEDIASTINAL STRUCTURES, INCLUDING THE HEART AND OFTEN THE LUNG, AND THEY FREQUENTLY CAUSE DEATH FROM THIS LOCAL DESTRUCTION.

THE HIGH-GRADE CANCERS, ON THE OTHER HAND, WHICH WOULD INCLUDE SMALL CELL ANAPLASTIC, WILL METASTASIZE BY THE LYMPHATICS IN THE BLOODSTREAM, AND REACH OTHER ORGANS AND CAUSE MISCHIEF THERE.

Q. SO IN ORDER FOR A THYMIC CANCER TO GET TO THE BRONCHI AND TO OTHER PARTS OF THE MEDIASTINUM AND BE A SMALL CELL, IT WOULD HAVE HAD TO GO TO LYMPH GLANDS?

A. NO, MA'AM. NO. YOU SEE, THE THYMUS GLAND OF THE HUMAN BEING LIES BASICALLY IN THE RETROSTERNAL SPACE. FREQUENTLY, IN PEOPLE, THERE ARE TWO TONGUES OF TISSUE THAT GO TO EITHER SIDE AS YOU GO DOWN THE ORGAN, AND FREQUENTLY THEY LIE AGAINST THE BRONCHUS IN THE MEDIASTINUM.

SO THAT THYMOMAS ORIGINATING FROM THE PORTION OF THE THYMUS OR THYMIC REMNANT THAT IS NORMALLY IN ANATOMICAL RELATION TO THE BRONCHUS, IT'S ALREADY THERE.

Q. THIS ISN'T A THYMOMA, DOCTOR. A THYMOMA IS A

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BENIGN DISEASE, ISN'T IT?

A. NO. MANY PEOPLE HAVE USED THE TERM "THYMOMA" TO INDICATE A BENIGN TUMOR OF THE THYMUS.

BUT AS I'M USING THE TERM HERE TODAY, I'M USING THE TERM "THYMOMA" COLLECTIVELY TO INDICATE ANY NEOPLASM OF THE THYMUS, WHETHER BENIGN OR MALIGNANT.

Q. YOU'D AGREE THAT MS. HENLEY DOESN'T HAVE A BENIGN DISEASE?

A. ABSOLUTELY.

Q. AND YOU'D AGREE THAT MS. HENLEY HAS A DISEASE THAT -- WHAT WAS THE DIFFERENTIATION YOU GAVE BETWEEN -- YOU

DIDN'T SAY EXTENSIVE, DID YOU?
A. I SAID HIGH-GRADE AND LOW-GRADE.
Q. HIGH-GRADE AND LOW-GRADE.
AND THIS WOULD BE HIGH-GRADE, WHAT MS. HENLEY HAS; CORRECT?
A. ABSOLUTELY.
Q. AND HIGH-GRADE THYMUS OR THYMIC CANCERS SPREAD THROUGH THE LYMPH NODES; CORRECT?
A. AS WELL AS LOCALLY IN THE MEDIASTINUM.
BUT BEFORE THEY SPREAD TO THE LYMPH NODES, THEY SPREAD THROUGH THE THYMUS GLAND. IT'S USUALLY POSSIBLE -- IT'S USUALLY POSSIBLE IN EXAMINING THYMIC CANCERS TO RECOGNIZE REMNANTS OF THYMUS, AND SOMETIMES IN TRANSITIONS FROM THE NORMAL STRUCTURES TO CANCER.
Q. NOW, DR. HENSLEY, YOU DIDN'T FIND PIECES OF THYMIC GLAND IN MS. HENLEY'S BIOPSY?
A. I DON'T KNOW. AS I INDICATED EARLIER, I BELIEVE

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IF YOU REVIEW WHAT I SAID THIS MORNING, YOU'LL FIND THAT I SAID THAT WE FOUND FAT TISSUE, AND THAT THE NORMAL HUMAN INVOLUTED THYMUS CONTAINS FAT TISSUE. IT COULD HAVE BEEN THYMUS TISSUE.
BUT IT MIGHT HAVE BEEN ADIPOSE TISSUE FROM THE MEDIASTINUM ITSELF, AND I CAN'T REALLY BE SURE WHICH.
Q. AND THE REST OF IT WAS TUMOR TISSUE; CORRECT?
A. YES, MA'AM.
Q. AND TUMOR TISSUE CAN OVERCOME LYMPH NODES, PARTICULARLY IF YOU HAVE -- IF YOU'VE TAKEN A SMALL, LITTLE BIOPSY?
A. I DON'T UNDERSTAND THE QUESTION.
Q. TUMOR, WHEN IT GOES TO THE LYMPH NODES, CAN DESTROY A LYMPH NODE, CAN'T IT?
A. YES.
Q. AND IF YOU'VE TAKEN A PIECE OF A BIOPSY AND YOU'RE LOOKING THROUGH THE MICROSCOPE AND YOU'RE LOOKING AT TUMOR, YOU DON'T KNOW WHAT THAT WAS BEFORE IT WAS TUMOR?
A. NO, THAT'S FALSE. AS A MATTER OF FACT, LYMPH NODES OF THE MEDIASTINUM DO NOT NORMALLY CONTAIN FAT CELLS.
AND CONSEQUENTLY, LOOKING AT THE BIOPSY AND SEEING THE FAT CELLS, I CAN CONFIDENTLY SAY THAT THAT WAS NOT LYMPH NODE.
Q. THE SMALL PART OF IT THAT WAS A FAT; CORRECT?
A. THAT PART OF IT WHICH WAS FAT.
Q. AND WITH RESPECT TO THE DIAGNOSIS OF A PRIMARY THYMIC CARCINOMA, YOU'RE FAMILIAR WITH AN ARTICLE BY SAUL SUSTER, S-U-S-T-E-R, AND CESAR, C-E-S-A-R, MORAN?

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A. YES, MA'AM.
Q. AND IT'S TRUE, IS IT NOT, THAT THEY SAY THAT THE DIAGNOSIS OF THYMIC CARCINOMA MUST ALWAYS BE ONE OF EXCLUSION?
A. YES. I FULLY AGREE WITH THAT STATEMENT.
Q. AND SO THAT I DON'T MISREAD --
A. I WOULD LIKE TO ADD SOMETHING, IF YOU DON'T MIND.
IN THAT SAME ARTICLE, THEY SAY THAT IT MIGHT BE NECESSARY TO --
Q. DOCTOR.
A. YES.
Q. I DON'T THINK THERE IS A QUESTION PENDING.
A. OH. I'M SORRY.

MS. CHABER: I'M SURE MR. OHLEMEYER WILL BE HAPPY TO ASK YOU WHATEVER QUESTIONS HE WANTS TO.
I'D LIKE TO HAVE MARKED AS PLAINTIFF'S NEXT IN ORDER AN ARTICLE TITLED "THYMIC CARCINOMA."
THE CLERK: PLAINTIFF'S EXHIBIT 78.
(DOCUMENT MORE PARTICULARLY DESCRIBED IN THE INDEX MARKED FOR IDENTIFICATION PLAINTIFF'S EXHIBIT # 78)
THE CLERK: DO YOU HAVE A COPY FOR THE JUDGE?
MS. CHABER: NO, I DON'T HAVE ANOTHER COPY.
MR. OHLEMEYER: EXCUSE ME, YOUR HONOR.
THE COURT: YES.
MR. OHLEMEYER: I'D LIKE TO SEE IT.

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THE COURT: YOU WANT TO SEE IT? SURE.
MS. CHABER: Q. THIS IS THE ARTICLE THAT WE'VE MARKED AS 78 THAT YOU'RE FAMILIAR WITH, DOCTOR?
A. (EXAMINING) SUSTER, YES.
Q. AND, DOCTOR, I'LL DIRECT YOU -- YOU DON'T HAVE GLASSES WITH YOU?
A. I DO.
Q. YOU DO. OKAY. SO IF YOU NEED TO READ ALONG, YOU'LL BE ABLE TO DO THAT.
DOCTOR, ISN'T IT TRUE THAT THE FOLLOWING STATEMENT WAS MADE BY SAUL SUSTER.
FIRST OF ALL, BEFORE I DO THAT, SAUL SUSTER WAS AT THE MT. SINAI MEDICAL CENTER AND UNIVERSITY OF MIAMI SCHOOL OF MEDICINE?
A. YES.
Q. AND CESAR MORAN IS FROM THE ARMED FORCES INSTITUTE OF PATHOLOGY IN WASHINGTON?
A. I BELIEVE SO.
Q. AND IT'S TRUE, IS IT NOT, THAT THEY STATE THE FOLLOWING AT PAGE 115:
"THE RENDERING OF A DIAGNOSIS OF PRIMARY SMALL CELL CARCINOMA OF THE THYMUS MUST BE BASED ON THE EXCLUSION OF A PRIMARY TUMOR ELSEWHERE"?
DO YOU AGREE THAT THAT IS WHAT THEY SAID?
A. NOT ONLY THAT, BUT I AGREE WITH THE STATEMENT.
Q. OKAY. AND WOULD YOU AGREE THAT THE NEXT SENTENCE READS AS FOLLOWS:
"THIS CAN BE VERY DIFFICULT TO ESTABLISH IN THE

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MAJORITY OF PATIENTS DURING LIFE, SINCE SMALL CELL CARCINOMA OF THE LUNG IS KNOWN TO METASTASIZE MASSIVELY TO THE MEDIASTINUM AT A VERY EARLY STAGE WHEN THE PRIMARY IS NOT DETECTABLE BY RADIOGRAPHIC MEANS"?
IS THAT A CORRECT READING OF THE NEXT STATEMENT?
A. THAT'S WHAT IT SAYS.
Q. AND YOU WOULD AGREE THAT IN THIS CASE, THE SURGEONS ELECTED NOT TO DO WASHINGS AND BRUSHINGS, CORRECT --
A. YES.
Q. -- IN MS. HENLEY'S CASE?
A. THEY DID.
Q. AND YOU WOULD AGREE THAT YOU'RE NOT QUARRELING WITH THEIR COMPETENCE TO MAKE THAT DECISION AT THE TIME THAT THEY RENDERED IT, ARE YOU?
A. IT'S A DECISION I WOULD DISAGREE WITH. BUT I

WOULD NOT SIT IN JUDGMENT OF THEIR REASONS FOR NOT DOING IT, BECAUSE I HAVEN'T TALKED WITH THEM, AND I DON'T KNOW WHAT THEIR THINKING WAS AT THE MOMENT.

BUT I WOULD REGARD THAT AS A CRITICAL MISTAKE THAT MAKES IT IMPOSSIBLE NOW TO BE SURE WHERE THE CANCER ORIGINATED FROM.

Q. YOU UNDERSTAND THAT THE SURGEON WHO PERFORMED THAT SURGERY DOESN'T THINK IT'S IMPOSSIBLE TO DETERMINE THE ORIGIN OF THE CANCER?

MR. OHLEMEYER: YOUR HONOR, I OBJECT. IT'S ARGUMENTATIVE.

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THE COURT: SUSTAINED.

MS. CHABER: Q. LET'S ASSUME, DOCTOR, THAT THE SURGEON WHO PERFORMED THAT SURGERY CAME INTO COURT AND TESTIFIED THAT THIS IS A SMALL CELL CANCER OF THE LUNG.

CAN YOU MAKE THAT ASSUMPTION?

A. I CAN ASSUME THAT HE SAID THAT.

Q. AND CAN YOU ASSUME FURTHER THAT THAT SURGEON WAS COMFORTABLE WITH THAT DIAGNOSIS, BASED ON ALL OF THE MATERIALS YOU HAVE EXAMINED?

A. NOT NECESSARILY. IF I WERE IN HIS SHOES, I WOULD NOT BE COMFORTABLE AT ALL. I DON'T THINK THAT THE WEIGHT OF EVIDENCE INDICATES THAT THE DIAGNOSIS OF LUNG CANCER WAS CORRECT, LOOKING BACK ON IT.

I WANT TO EMPHASIZE THAT HERE WE HAVE THE BENEFIT OF LOOKING AT THE TOTAL PICTURE, IN RETROSPECT, BUT I'M NOT QUARRELING WITH PEOPLE WHO DIDN'T HAVE THE BENEFIT OF THAT VIEW.

Q. DO YOU KNOW, SIR, WHETHER OR NOT THE SURGEON HAS REVIEWED ALL THE MATERIALS THAT YOU'VE REVIEWED? YOU DON'T KNOW THAT, DO YOU?

A. I'M TALKING ABOUT THE DIFFERENCE OF JUDGMENT AT THE TIME THE DIAGNOSIS WAS MADE BACK IN JANUARY, I BELIEVE.

Q. AT THE TIME THAT THAT DIAGNOSIS WAS MADE, IS IT FAIR TO SAY, DOCTOR, THAT THERE WASN'T ANYBODY IN THE COURSE OF THIS THAT INDICATED A DIFFERENTIAL OR A CONSIDERATION THAT THIS WAS A THYMIC ORIGIN CANCER?

A. THE SPECIFIC INFORMATION WAS NOT IN THE RECORDS THAT I READ, SO I REALLY CAN'T SAY.

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Q. AND, DOCTOR, YOU WOULD AGREE THAT SMALL CELL CARCINOMAS OF THE LUNG ARE KNOWN TO METASTASIZE MASSIVELY TO THE MEDIASTINUM?

A. WHICH DID NOT OCCUR IN THIS CASE.

BUT YES, I AGREE WITH THAT STATEMENT.

Q. DO YOU AGREE THAT SMALL CELL CARCINOMAS OF THE LUNG CAN METASTASIZE TO THE MEDIASTINUM AND NOT HAVE A LESION BEING SEEN IN THE BRONCHUS?

A. I DO. THAT'S EXACTLY WHY WE USE THOSE TECHNIQUES THAT WE PREVIOUSLY TALKED ABOUT.

Q. DO YOU AGREE THAT YOU CANNOT RULE OUT MS. HENLEY'S CANCER BEING A LUNG CANCER?

A. NO, NOT WITH 100 PERCENT CERTAINTY.

Q. AND, DOCTOR, I JUST WANT TO ASK YOU, IN LIGHT OF THE TIME, JUST ONE OR TWO FINAL QUESTIONS.

DR. HENSLEY, DO YOU BELIEVE THAT CIGARETTE SMOKING CAUSES ANY DISEASE?

A. WELL, I'M NOT AN EXPERT ON ALL OF THE POSSIBLE DISEASES THAT HAVE BEEN RELATED TO CIGARETTE SMOKING. IF YOU WISH TO CONFINE IT TO THE QUESTION OF CANCER, I HAVE TO

SAY THAT THERE IS STRONG STATISTICAL EVIDENCE TO CONSIDER THE HYPOTHESIS THAT I REGARD AS YET UNPROVEN, THAT CIGARETTE SMOKING MAY CAUSE CERTAIN CANCERS OF THE LUNG, BUT CERTAINLY NOT ALL OF THEM.

AND I WANT TO EMPHASIZE THAT WE'RE TALKING HERE NOT ABOUT HARD SCIENTIFIC CONCLUSIONS BUT ABOUT HYPOTHESES THAT ARE INCOMPLETELY SUPPORTED BY THE FACTS AT PRESENT.

Q. FIRST OF ALL, YOU'VE NEVER WORKED ON ANY SURGEON

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GENERAL COMMITTEES OR BEEN INVOLVED IN WRITING ANY OF THE SURGEON GENERAL REPORTS, HAVE YOU?

A. NO, MA'AM.

Q. HAVE YOU HAVE READ THE SURGEON GENERAL REPORTS ON THE HEALTH CONSEQUENCES OF SMOKING?

MR. OHLEMEYER: YOUR HONOR, I DON'T WANT TO INTERRUPT, BUT THIS IS BEYOND THE SCOPE OF THE DIRECT.

MS. CHABER: IT GOES TO CREDIBILITY ISSUES AND IT GOES TO BIAS.

THE COURT: LET ME JUST HAVE A VERY, VERY BRIEF SIDEBAR WITH YOU.

(COURT AND COUNSEL CONFER OUTSIDE
THE PRESENCE OF THE JURY)

THE COURT: FOR THE RECORD, DO YOU WANT TO WITHDRAW AND REPHRASE THAT QUESTION?

MS. CHABER: SURE.

Q. DR. HENSLEY, MS. HENLEY HAD A SMOKING HISTORY, DID SHE NOT?

A. SHE DID.

Q. AND SHE HAD A SMOKING HISTORY OF SOMEWHERE BETWEEN 90 AND 120 PACK YEARS?

A. I DON'T REMEMBER, BUT I BELIEVE YOU.

Q. AND DOCTOR, LET ME TRY THIS A LITTLE MORE DIRECTLY.

DO YOU BELIEVE THAT CIGARETTE SMOKING CAUSES LUNG CANCER?

MR. OHLEMEYER: ASKED AND ANSWERED, YOUR HONOR.

MS. CHABER: HE NEVER ANSWERED IT.

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THE COURT: I WILL ALLOW IT.

THE WITNESS: I DON'T THINK THAT THE SCIENTIFIC STANDARDS HAVE BEEN MET THAT WOULD PERMIT A SCIENTIFIC ANSWER TO YOUR QUESTION.

I WANT TO EMPHASIZE THAT I AM IN NO WAY DISAGREEING WITH THE SURGEON GENERAL'S REPORT FROM A PUBLIC HEALTH STANDPOINT. I BELIEVE IT EXPRESSES WELL-FOUNDED CONVICTIONS OF RESPECTABLE SCIENTISTS.

I DON'T BELIEVE THEY MET THE STANDARDS OF SCIENTIFIC PROOF, BUT I CERTAINLY THINK THAT CIGARETTE SMOKING IS AN IMPORTANT RISK FACTOR IN THE PRODUCTION OF CANCERS IN SOME CANCERS OF THE LUNG. NOBODY WOULD DISAGREE WITH THAT.

MS. CHABER: Q. DR. HENSLEY, SEE IF YOU CAN ANSWER THIS YES OR NO, AND THEN YOU CAN EXPLAIN AS MUCH AS YOU WANT TO: DO YOU BELIEVE THAT CIGARETTE SMOKING CAUSES LUNG CANCER?

MR. OHLEMEYER: ASKED AND ANSWERED.

THE COURT: SUSTAINED.

MS. CHABER: Q. DO YOU BELIEVE CIGARETTE SMOKING CAUSES EMPHYSEMA?

A. I THINK THE EVIDENCE FOR THAT IS VERY POOR.

Q. DO YOU THINK THAT CIGARETTE SMOKING CAUSES

CHRONIC BRONCHITIS?
A. IT'S A RISK FACTOR IN THE DEVELOPMENT OF BRONCHITIS. IT'S CERTAINLY NOT THE CAUSE OF CHRONIC BRONCHITIS.
Q. I USED THE WORD "CAUSE" THE SAME WAY THE SURGEON

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GENERAL USED IT IN THE 1979 REPORT, AS A SIGNIFICANT EFFECTUAL RELATIONSHIP BETWEEN AN AGENT AND AN ASSOCIATED DISORDER OR DISEASE.
DO YOU BELIEVE, DOCTOR, THAT CIGARETTE SMOKING CAUSES EMPHYSEMA?
A. THIS IS NOT SCIENTIFICALLY LOGICAL. WHAT YOU JUST ASKED ME TO DO IS ABANDON SCIENTIFIC LOGIC AND AGREE WITH THE PRINCIPLE OF GUILT BY ASSOCIATION.
THOSE STATEMENTS ARE BASED ON STATISTICAL STUDIES. THE BEST THE STATISTICS CAN DO IS TO HELP US TO FORMULATE SCIENTIFIC HYPOTHESES, WHICH NEEDS TESTING BEFORE SCIENTIFIC EVIDENCE IS BROUGHT FORWARD.
Q. DOCTOR --
A. SO I CANNOT POSSIBLY ANSWER IT IN THOSE TERMS.
Q. DR. HENSLEY, YOU'RE AWARE THAT THE SURGEON GENERAL OF THE UNITED STATES, THE WORLD HEALTH ORGANIZATION, THE INTERNATIONAL ASSOCIATION OF RESEARCH OF CANCER, HAVE ALL STATED THAT CIGARETTE SMOKING CAUSES THE DEFINITION THAT I JUST GAVE FOR LUNG CANCER?
A. IN 1964, IN THE SURGEON GENERAL'S REPORT, HE SAID THAT THEY WOULD LIKE TO PRESENT EVIDENCE THAT WOULD LEAD TO THE CONVICTION OF CAUSATION WITH THE CLASSICAL EXACTNESS OF ARISTOTLE.
WHEN THEY CONCLUDED THE RECORD, THEY ABANDONED THOSE PRINCIPLES OF LOGIC AND SCIENCE AND SAID THAT THEY CAME TO A CONVICTION ABOUT CAUSATION BASED ON THE INFORMATION THAT WAS CONTAINED IN THAT REPORT.
I HEARTILY APPLAUD THEM FOR THAT, AND I AGREE

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WITH THEIR EFFORT, AND I THINK IT WAS AN IMPORTANT CONTRIBUTION TO PUBLIC HEALTH, BUT I CANNOT ACCEPT IT AS A SCIENTIFICALLY PROVEN HYPOTHESIS.
BUT DON'T MISTAKE MY MEANING. I RESPECT THEIR WORK.
Q. DR. HENSLEY, 34 YEARS LATER, ALL OF THE ORGANIZATIONS, THE SURGEON GENERAL, THE WORLD HEALTH ORGANIZATION, THE INTERNATIONAL ASSOCIATION FOR RESEARCH OF CANCER, THEY HAVE ALL CONCLUDED A CAUSE-AND-EFFECT RELATIONSHIP BETWEEN LUNG CANCER AND CIGARETTE SMOKING --
A. COUNSELOR, THIS IS --
MR. OHLEMEYER: I'M SORRY. I OBJECT, YOUR HONOR.
MS. CHABER: I WASN'T FINISHED WITH MY SENTENCE.
MR. OHLEMEYER: IT IS ARGUMENT, NOT A QUESTION.
THE COURT: THERE ISN'T A QUESTION YET.
THE WITNESS: I'M SORRY.
THE COURT: IF THERE IS A QUESTION AND IF YOU HAVE AN OBJECTION, MAKE IT, BUT WE HAVEN'T HEARD A QUESTION.
MS. CHABER: Q. IS THAT SOMETHING THAT YOU DISAGREE WITH TODAY, IN 1999?
MR. OHLEMEYER: OBJECTION. IT'S ARGUMENTATIVE, AND IT'S BEEN ASKED AND ANSWERED --
THE COURT: SUSTAINED.
MR. OHLEMEYER: -- FOUR TIMES.
THE COURT: SUSTAINED.

MS. CHABER: I HAVE NOTHING FURTHER.
THE COURT: ANYTHING FURTHER?

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MR. OHLEMEYER: I JUST HAVE TWO OR THREE.

REDIRECT EXAMINATION

BY MR. OHLEMEYER: Q. DR. HENSLEY, WHEN YOU DIAGNOSE CANCER, DO YOU DO IT BASED ON PROBABILITIES OR BASED ON ANATOMY?

A. ANATOMY AND PATHOLOGY.

Q. AND ARE PROBABILITIES MORE OF LESS USEFUL TO YOU IN YOUR WORK IN DIAGNOSING CANCER THAN ANATOMICAL INFORMATION?

A. STATISTICAL PROBABILITIES ARE PRACTICALLY NO VALUE IN MY WORK.

Q. DOES THE ANATOMICAL EVIDENCE IN THIS CASE SUGGEST THAT IT'S MORE OR LESS LIKELY THAT MS. HENLEY'S CANCER STARTED IN HER LUNG?

A. IT'S LESS LIKELY. THERE'S NO EVIDENCE THAT THE CANCER STARTED IN THE LUNG, AND THERE'S NO EVIDENCE IN THE MEDICAL RECORD OR THE X-RAYS THAT IT EVER INVOLVED THE LUNG AT ALL.

Q. WHAT ABOUT THE LYMPH NODES?

A. THERE'S NO EVIDENCE THAT THE LYMPH NODES ARE INVOLVED, FROM A PATHOLOGICAL STANDPOINT.

Q. WHY WOULD THAT SORT INVOLVEMENT BE IMPORTANT IF YOU WERE TRYING TO DETERMINE WHETHER THE CANCER STARTED IN THE LUNG?

A. WELL, SMALL CELL ANAPLASTIC CARCINOMAS STARTING IN THE LUNG VIRTUALLY ALWAYS METASTASIZE MASSIVELY TO THE LYMPH NODES, WHICH DID NOT OCCUR IN THIS CASE.

THERE IS A SINGLE MASS, AND IT WASN'T SITUATED IN

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THE AREA WHERE SMALL CELL CANCER USUALLY METASTASIZES TO.

MR. OHLEMEYER: THANK YOU, DOCTOR. THAT'S ALL I HAVE.

THE COURT: ANYTHING FURTHER FOR THE DOCTOR?

MS. CHABER: NO, YOUR HONOR.

THE COURT: MAY THE DOCTOR BE EXCUSED?

MS. CHABER: YES.

MR. OHLEMEYER: YES. THANK YOU, DOCTOR.

THE COURT: OKAY. DOCTOR, YOU ARE EXCUSED.

(WITNESS EXCUSED)

THE COURT: AND JURORS, LET'S KIND OF COMPROMISE ON LUNCH AND LET'S TAKE AN HOUR AND 20 MINUTES.

JUROR NO. 3: I JUST WANT TO SAY THAT I HAVE A VERY IMPORTANT MATTER THAT I NEED TO TAKE CARE OF AT LUNCHTIME.

THE COURT: WHAT DO YOU WANT TO TAKE FOR LUNCH? IT'S 12:25. WHEN DO YOU WANT TO COME BACK?

JUROR NO. 3: AN HOUR AND A HALF.

THE COURT: WE'LL COME BACK AT 2:00 O'CLOCK. PLEASE CONTINUE TO FOLLOW THE ADMONITION OVER THE LUNCH HOUR AND HAVE A GOOD LUNCH. WE'LL SEE YOU AT 2:00 O'CLOCK.

(LUNCH RECESS TAKEN AT 12:25 P.M.)

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